Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

PULL POSTING NOTICE
FOR THE STATE OF:

COLORADO
COLORADO
COLORADO
FLORIDA
FLORIDA

COLORADO
COLORADO
COLORADO
FLORIDA
NEVADA

Starr Indemnity & Liability Co
399 Park Avenue
New York NY 10022-0000

HOSPITAL COURIERS, LLC
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

Named Insured: **HOSPITAL COURIERS, LLC**

Effective Date: **09/23/2019**

Agency Name: **CLAUDIA MANDATO**

Welcome

Thank you for placing your Workers' Compensation coverage with Starr.

Our Company

Starr Companies is a global insurance and financial services organization that provides innovative risk management solutions. We provide a range of property and casualty coverages as well as accident & health and specialty lines, including risks with international exposures. Our unparalleled leadership and unsurpassed expertise will help you succeed in an ever-changing world of risk. For more information, visit us at www.starrcompanies.com.

Our Mission is to consistently provide our clients with solutions in asset protection and risk management. We are dedicated to offering superior underwriting and loss control services. We respond to our client's needs in focused and innovative ways by developing products and services that will enable their growth and success.

We maintain a global focus and build on our international roots to enhance our presence in existing and emerging markets worldwide. We are committed to building long term relationships based on mutual trust and respect, and to providing services that will become the standard by which our competitors are judged.

Terms and Agreements

See your policy for Terms and Agreement information.

STARR INDEMNITY

A MEMBER OF STARR COMPANIES

WORKERS COMPENSATION CLAIMS REPORTING

ALL Workers Compensation Claims, regardless of severity or location should be reported to the TPA immediately. The TPA Claims Intake Center is ready to accept new losses.

All claims must be reported by email, fax or by postal mail.

To expedite the handling of your claim, the following information must be provided when reporting a claim:

- **CLIENT /PROGRAM NAME:** HOSPITAL COURIERS, LLC
- **POLICY NUMBER:** 100 0003868
- **TPA NAME:** GALLAGHER BASSETT SERVICES INC
- **TPA CLIENT CODE NUMBER:** VDN2119
- **TPA EMAIL:** tnwclaims@tnwinc.com
- **TPA FAX NUMBER:** 800-748-6159
- **TPA MAILING ADDRESS:** 2915 Premiere Parkway, ST 350

  Duluth GA 30097-5241
- **TPA TELEPHONE NUMBER:** 855-782-7750

The TPA Claims Intake Center will review the notice upon receipt and assign the claim to the appropriate Branch Office. A claim acknowledgement letter will be transmitted to the designated individuals at the client's office advising of the TPA's claim number and the name and contact information of the adjuster assigned to the claim.

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING BUREAU ("WCIRB")
COMMUNICATION REQUIRING REPORTING OF ALL INSURED FIRST AID CLAIMS
EFFECTIVE JANUARY 1, 2017

The California WCIRB issued the attached Bulletin, which clarifies the reporting requirements for Small Medical Only or First Aid Claims. This was approved by the CA Insurance Commissioner on October 14, 2016.

Small Medical Only or First Aid Claims:

Small Medical Only or First Aid Claims are defined in California Labor Code Section 5401(a) as follows:

> "first aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel.

Reporting Requirement Clarifications and Reasons:

The above definition of first aid has now been added to the *California Workers' Compensation Uniform Statistical Reporting Plan – 1995* which became effective January 1, 2017. This clarifies that first aid or small medical only claims must be reported if medical care is provided and costs are incurred, regardless of whether the payments are made by an insurer or insured. These claims can be reported like any other previously reported medical only claim.

The WCIRB has issued prior bulletins in this regard and the bulletin emphasizes that this is a long-standing position of the California Department of Insurance. The goal is to ensure consistent and complete reporting without causing a disadvantage for those employers that do report all required injuries as compared to those that do not.

Recommendations:

In order to comply with the WCIRB's revised reporting guidelines insured employers must report all claims, including any medical costs previously paid as first aid within 5 days of knowledge[1]. In addition, physicians are required to file a Doctor's First Report of Occupational Injury or Illness with the appropriate Starr Companies third party administrator within 5 days of the first examination. We recommend reminding your designated

[1] Title 8, CCR §14001

industrial clinics of this requirement to assure compliance. This information will then be used to report the information and data necessary to California.

What is the Impact?

There are expected changes to frequency caused by the reporting of first aid claims, which may impact experience modifications used for insurance ratings. There may also be claims administration costs related to reporting claims that may not have previously been submitted. There should also be some benefit to paying medical costs pursuant to fee schedule reductions and any applicable provider network savings.

Potential Penalties:

There are potential civil penalties between $50 and $200 for a pattern or practice or willful violations for failure to file Employer's First Reports or Doctor's First Report of Occupational Injury reports as well as penalties up to $5,000 for delays in reporting cases involving serious injury or illness or death.[2]

If any additional information that impacts this communication becomes available, we will provide updates.

If you have questions contact your claims TPA (Third Party Administrator).

[2] CA Labor Code §6409.1, §6413.5

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STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

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Benefits. Workers' compensation benefits include:

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- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical o r mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, a your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group *before* you are injured.You must obtaintheir agreement to treat you for your work injury.Forinstructions, see the written information about workers' compensation that your employer is required to give to new employees.

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   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPNor HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
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Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group *before* you are injured.You must obtaintheir agreement to treat you for your work injury.Forinstructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPNor HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: _____

MPN Effective Date: _____ MPN Identification number: _____

If you need help locating an MPN physician, call your MPN access assistant at: _____

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: _____

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator GALLAGHER BASSETT SERVICES INC Phone 855-782-7750

Workers' compensation insurer Starr Indemnity & Liability Co (Enter "self-insured" if appropriate)

You can also get free information from a State Division of Workers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401.** Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured Workers."

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo el lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas médic as, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le imp ida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, antes de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos or departamento de policia. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está At endiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado**. Si usted está recibiendo tratamiento de parte de unmédico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN :

Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número gratuito de la MPN vigente: _____

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: _____
Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: _____

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contrado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos GALLAGHER BASSETT SERVICES INC Teléfono 855-782-7750

Asegurador del Seguro de Compensación de trabajador Starr Indemnity & Liability Co (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Comp ensación de T rabajdores . El Oficial de Información y Asistencia más cercano se localiza en: _____
o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "ompensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo el lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas médic as, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le imp ida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, antes de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos or departamento de policia. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está At endiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
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Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número gratuito de la MPN vigente: _____

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Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contrado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos GALLAGHER BASSETT SERVICES INC Teléfono 855-782-7750

Asegurador del Seguro de Compensación de trabajador Starr Indemnity & Liability Co (Anote "autoasegurado" si es apropiado)

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o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "ompensación del Trabajador de California Una Guía para Trabajadores Lesionados."

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Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

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- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número gratuito de la MPN vigente: _____

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Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: _____

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¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contrado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos GALLAGHER BASSETT SERVICES INC Teléfono 855-782-7750

Asegurador del Seguro de Compensación de trabajador Starr Indemnity & Liability Co (Anote "autoasegurado" si es apropiado)

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o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "ompensación del Trabajador de California Una Guía para Trabajadores Lesionados."

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Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo el lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas médic as, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le imp ida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, antes de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos or departamento de policia. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesión, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está At endiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado**. Si usted está recibiendo tratamiento de parte de unmédico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN :

Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número gratuito de la MPN vigente: _____

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: _____
Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: _____

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contrado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos GALLAGHER BASSETT SERVICES INC Teléfono 855-782-7750

Asegurador del Seguro de Compensación de trabajador Starr Indemnity & Liability Co (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Comp ensación de T rabajdores . El Oficial de Información y Asistencia más cercano se localiza en: _____
o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "ompensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

STARR INDEMNITY & LIABILITY CO

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303-318-8700 or toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17th Street, Suite 400, Denver, CO 80202-3626

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Información De Indemnización Por Accidentes Laborales De Colorado

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

STARR INDEMNITY & LIABILITY CO

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

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Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
633 17th St. Suite 400, Denver, CO 80202-3660

Cualquier información proveída abajo viene directamente de su empleador y es exclusivo de este lugar del empleo:

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

COLORADO WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

Colorado law requires that we provide a notice outlining the available deductibles for medical expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY issued by a member company of the Starr Companies. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced based on the deductible amount selected and a credit amount determined by Starr. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your Colorado operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place an "X" next to the deductible you want and return the signed, completed form to Starr or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective the date we receive the form in our office.

	Deductible Amount
_____	$500
_____	$1,000
_____	$1,500
_____	$2,000
_____	$2,500
_____	$5,000
_____	$10,000
_____	$13,500
_____	$15,500

Signed: Date:

Authorized Representative
of Named Insured

Named Insured: HOSPITAL COURIERS, LLC

Named Insured's Mailing Address 7200 S ALTON WAY STE A360
CENTENNIAL CO 80112

Binder/Policy Number: 100 0003868

Name and Address of Agent: CLAUDIA MANDATO
444 W 47TH ST STE 900
KANSAS CITY MO 64112

Form WC PN CO (01-15)

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

TEXAS COMPLAINT NOTICE

Should any dispute arise about your premiums or about a claim that you have filed, contact the agent or write to the company that issued the policy. If the problem is not resolved, you may also write the State Board of Insurance, Department C, 1110 San Jacinto, Austin, Texas 78786. This notice of complaint procedure is for information only and does not become a part or condition of this policy.

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TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE DISEASES AND ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

TO: Law Enforcement Officers, Fire Fighters, Emergency Medical Service Employees, Paramedics, and Correctional Officers -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, AN EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO A REPORTABLE DISEASE, INCLUDING HIV INFECTION, MUST BE TESTED FOR THE DISEASE NOT LATER THAN THE 10TH DAY AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A SWORN AFFIDAVIT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF THE DISEASE. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of Health. Exposure criteria and testing protocol must conform to Texas Department of Health requirements.

TO: All State Employees -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, A STATE EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, MUST BE TESTED FOR HIV WITHIN 10 DAYS AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A WRITTEN STATEMENT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF HIV INFECTION. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

FOR ADDITIONAL INFORMATION: TALK TO YOUR EMPLOYER OR CALL THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION AT 1-800-372-7713. ALSO, CONTACT THE TEXAS DEPARTMENT OF HEALTH (TDH) TO ENSURE FULL COMPLIANCE WITH THE HEALTH AND SAFETY CODE AND TDH RULES.

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NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission **Revised 10-01-2017**

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

HOSPITAL COURIERS HOLDINGS, LLC

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name STARR INDEMNITY & LIABILITY CO

Address 399 PARK AVENUE **Telephone** (646)227-6563

City/Town New York **State** New York **Zip Code** 10022

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address See Attached **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted: _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

Workers' Compensation Commission District Offices

District 1— Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2— Norwich

90 Sachem Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5— Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 596-4318

District 6— New Britain

233 Main Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7— Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8— Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law
which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.

Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE. De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficio son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

STARR INDEMNITY & LIABILITY CO — **(646)227-6400**

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

399 PARK AVENUE
NEW YORK, NEW YORK 10022

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: KDOL.wc@ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

Kansas
Department of Labor

Workers Compensation Information for Kansas Employers and Employees

K-WC 25 (Rev. 5-15)

Copies of election forms, accident reports, the Posting Notice (K-WC 40-A) and all other mandated posters are available to download at www.dol.ks.gov/WorkComp/frmpub2.aspx.

For additional information on workers compensation benefits, employer guidelines and other general information, contact:

Kansas Department of Labor
Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603-3105
(785) 296-4000
(800) 332-0353
Email: wc@dol.ks.gov
Website:www.dol.ks.gov

Follow us:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

For more information on workers compensation insurance rates and insurance carrier conduct, contact:

Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612-1678
(785) 296-3071
(800) 432-2484
Email: commissioner@ksinsurance.org
Website: www.ksinsurance.org

Table of Contents

What is Workers Compensation?

Workers compensation is a required insurance plan provided by the employer to pay employee benefits for job-related injuries, disability or death that arise out of and in the course of employment.

Per K.S.A. 44-508, an injury by accident shall be deemed to arise out of employment if:

- There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
- The accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment.

The words “arising out of and in the course of employment” as used in the Workers Compensation Act shall not be construed to include:

- Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;
- accident or injury which arose out of a neutral risk with no particular employment or personal character;
- accident or injury which arose out of a risk personal to the worker; or
- accident or injury which arose either directly or indirectly from idiopathic causes.

Benefits are paid at the employer’s expense. Coverage begins the first day on the job.

The present law covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of $20,000 or less. All payroll is taken into account, including that paid in Kansas or elsewhere. If the employer is a sole proprietor or a partnership, the wages paid to the owners and any of their family members are not used in the computation of the gross annual payroll. Per K.A.R. 51-11-6, the provision in K.S.A. 44-505 excluding the payroll of workers who are members of the employer's family shall not apply to corporate employers. A corporate employer's payroll for purposes of determining whether the employer is subject to the workers' compensation act shall be determined by the total amount of payroll paid to all corporate employees even when a corporate employee has elected out of the workers' compensation act pursuant to K.S.A. 44-543.

Employees who are disabled due to a job-related injury or disease are entitled to:

- medical expenses to treat the job-related injury or illness; and
- income benefits to replace part of the wages lost due to disability.

If death results from a job-related injury or disease, benefits may be paid to the surviving spouse, dependents or heirs.

Purpose of the Law

Kansas passed its first workers compensation law in 1911. By regulating litigation and benefits, the law is designed to protect the interests of both employers and employees. Employers benefit by substituting a known expense (premiums) for the risk of large, unbudgeted expenses in the event of serious employee disabilities. Employees benefit because negligence of the employer is not an issue in determining liability. Workers compensation coverage is a no-fault system. The provisions of the Workers Compensation Act shall be applied impartially to both employers and employees. While initially aimed at hazardous jobs, the law now covers most workers.

Elections

Elections in or out of the Workers Compensation Act are options available to employers or employees. Depending on the circumstances, options may be available for:

- non-covered employers – e.g., those with payrolls of $20,000 or less or in certain agricultural pursuits;
- corporate employees owning 10 percent or more of stock;

- individuals, proprietors or partnerships;
- employers seeking coverage for volunteers and other non-covered workers; and
- volunteer directors, officers or trustees of a nonprofit organization.

Example: A two-person partnership has two employees – a family member and a non-family member – and an annual payroll of $15,000. The partnership may elect to purchase coverage under the Act and to extend such coverage to both employees. The partners are not covered because they are considered to be the employer.

Election forms can be found on online at www.dol.ks.gov.

Employee Rights and Responsibilities

Kansas law protects an employee's right and ease in obtaining workers compensation. Specifically:

- An employee cannot be fired, demoted or otherwise discriminated against for filing a claim in good faith.
- Employees must be informed of their rights and responsibilities in case of injury. In the event of employee death, such information must be furnished to the employee's beneficiaries.
- Employees must not be charged for the payment of workers compensation claims. Employers cannot deduct from pay or benefits to pay insurance premiums or claims.
- Employees may be entitled to compensation benefits from an employer subject to the Act regardless of insurance coverage.
- Employees may obtain free assistance by contacting the Workers Compensation Ombudsman's office at (800) 332-0353 or (785) 296-4000.
- The law provides specific penalties for employee or employer fraud in workers compensation cases. For assistance or more information, or to report suspected fraud, contact the Workers Compensation Ombudsman or the Fraud and Abuse office at (800) 332-0353 or (785) 296-4000.

Employer Responsibilities

Workers Compensation Insurance

Most employers are required by law to provide for the payment of workers compensation claims, at no expense to the employee. Employers shall satisfy this requirement in one of three ways:

- **Workers compensation insurance:** obtained from a licensed insurance carrier; the employer pays the premiums and the insurance company pays the claims. The insurance carriers are regulated by the Kansas Insurance Department.
- **Self-insurance:** an individual employer must demonstrate to the State the financial ability to pay any claims that might arise. This program is administered by the Division of Workers Compensation.
- **Group-funded pool:** a group of employers meeting certain statutory requirements may form a self-insurance program to jointly insure their ability to pay claims. This program is administered by the Kansas Department of Insurance.

Intentional failure to provide for workers compensation payment in one of the above ways is a **class A misdemeanor** and subjects the employer to a civil penalty in an amount twice the annual premium the employer would have paid for insurance or $25,000, whichever amount is greater.

Employment categories excluded from the law are:

- certain agricultural pursuits;
- realtors who qualify as independent contractors;
- employers with gross annual payrolls of $20,000 or less;
- firefighters belonging to a firefighters relief association which has waived coverage under the workers compensation law; and
- certain owner-operator vehicle drivers covered by their own occupational accident insurance policy.

OTHER REQUIREMENTS

- Employers must post written notice K-WC 40-A advising employees what to do in case of injury.
- Per K.S.A. 44-557, "it is...the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained."

  As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

- **Immediately upon learning of an employee's injury or death, the employer must furnish written information to the employee or employee's dependents on available benefits, the claims process, an employer or insurance company contact for workers compensation claims, and other matters as required by law.** Forms K-WC 27-A and K-WC 270-A (Spanish) are available from the Division of Workers Compensation website at www.dol.ks.gov/WorkComp/frmpub2.aspx.
- An insurer or self-insured employer shall provide the following notice to an insured worker on or with the first check for temporary disability benefits: *Warning: Acceptance of employment with a different employer that requires the performance of activities you have stated you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in loss of future benefits and restitution of prior workers compensation awards and benefits paid.*

If you need assistance, call (800) 332-0353 or (785) 296-4000.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014, is outlined in K.A.R. 51-9-17.

Categories of Disability Benefits

Temporary Total Disability

Exists when the employee, on account of injury, is unable to engage in any type of substantial and gainful employment. Benefits are paid for the duration of the temporary total disability (TTD). There is a one-week waiting period (seven calendar days) before TTD benefits are paid. If the disability continues for three consecutive weeks, the employee is reimbursed for the waiting period. Employees may collect medical benefits during the first week. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum. Temporary total compensation may not exceed $130,000 per injury.

Employees may **not** collect temporary total disability and unemployment benefits for the same weeks.

Temporary Partial Disability

Exists when the worker returns to any employment at a wage less than the time of injury wage. Compensation is calculated on a weekly basis and is paid until the wage loss is no longer present or the benefit maximum is reached, whichever comes first.

Benefits are 66.67 percent of the difference between the employee's average gross weekly wage before the injury and the employee's wage after the injury. Benefits may not exceed the state's statutory maximum.

Permanent Partial Scheduled Disability

Exists when there is complete or partial loss of or loss of use of a body part, such as an arm, due to a job-related injury. Compensation for permanent partial scheduled disability is limited to a percentage of the following schedule. A healing period is available in cases of amputation. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum cap of $130,000.

Benefit Information Schedule

Loss of or loss of use of:	Weeks Paid:
Shoulder	225
Arm	210
Forearm	200
Hand	150
Leg	200
Lower leg	190
Foot	125
Eye	120
Hearing, both ears	110
Hearing, one ear	30

Loss of or loss of use of:	Weeks Paid:
Thumb	60
1st (index) finger	37
2nd (middle) finger	30
3rd (ring) finger	20
4th (little) finger	15
Great toe	30
Great toe, end joint	15
Each other toe	10
Each other toe, end joint only	5

Permanent Partial General Disability

Exists when a worker is disabled in a manner which is partial in character and permanent in quality, and which is not covered by the schedule above. For example, disability involving the back or the loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity; or the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or

foot of the other lower extremity; or the loss of or loss of use of both eyes which is partial in character and permanent in quality are whole body disabilities and are not covered by the above schedule. Compensation for such “non-scheduled” or “whole body” disability is based on the greater of the following: the percentage of functional impairment; or, the employee’s reduced ability to perform work tasks and the average weekly wage the employee is capable of earning after the injury. Employees earning 90 percent of pre-injury wage are limited to functional impairment.

Calculating Permanent Partial General Disability Benefits

1. **Calculate weekly benefit rate by identifying the smaller of these two amounts:** Gross average weekly wage x 66.67 percent; or the statutory maximum.

2. **Calculate allowable weeks of compensation:** Begin with 415 weeks. Subtract from 415 the number of weeks of temporary total disability paid, excluding the first 15 weeks of such temporary total paid. Multiply the difference by the percentage of disability.

3. **Calculate total benefits:** Multiply weekly benefit rate by allowable weeks of compensation.

Example: Average weekly wage is $875 at date of accident *(7/10/2011)*. Employee has collected 25 weeks of temporary total disability and has a 25 percent disability rating.

Weekly benefit rate: (use lesser amount)
$875 x .6667 = $583.36
statutory maximum *(as of 7/1/11)* $555

Allowable weeks of compensation:
415 - [25-15] = 415 - 10 = 405 weeks
405 weeks x .25 = 101.25 weeks

Maximum benefit amount:
101.25 weeks x $555 = $56,193.75

Our website has a Workers Compensation Calculation Program. The date program allows you to calculate time between two dates or to calculate the addition of days to a known date. The scheduled injury and whole body injury programs will allow you to compute the compensation benefits due to the claimant. Step-by-step instructions are provided for each program.

Permanent Total Disability

Exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, both legs or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall also constitute permanent total disability.

Benefits are 66.67 percent of an employee’s average gross weekly wage, but not less than $25 nor more than the statutory maximum. Total compensation may not exceed $155,000 per injury.

An employee is not allowed to receive more than one award of permanent total disability in a lifetime.

How Rates are Determined

Workers compensation insurance in Kansas is mandated by state law for most but not all employers. The premiums paid by the employers should be sufficient to cover the claims incurred by their insurance companies. Rates are adjusted based on the most recent premiums, investment income and losses reported by the insurance companies. The National Council on Compensation Insurance (NCCI) submits these rates annually to the insurance commissioner for approval.

The NCCI is a ratemaking organization, licensed by the Insurance Department, whose membership is primarily comprised of insurance companies. They develop the annual rate change needed based on the losses and premium reported to them by their member insurance companies.

The Kansas Insurance Department regulates the rates charged in Kansas. Each year, the Insurance Department reviews premiums, claims costs and other relevant data submitted by the NCCI to determine whether a rate change is supported. Currently, about 70 cents of every $1 collected in premiums is projected to cover the cost of paying workers compensation claims. Approximately 27.5 percent of each dollar is used by insurance carriers to cover other costs of doing business – e.g., administrative expenses, salaries and overhead. The margin of profit is projected at roughly 2.5 percent plus the earnings on investments.

After reviewing the rate filing, the commissioner of insurance generally approves an "overall" statewide premium change. This "overall" change is stated as a percentage (for example, a five percent overall increase); however, individual classification base rates may increase or decrease more than the "overall" change. Individual classification base rates must continue to reflect the experience (premiums and losses) of employers in each classification.

Premium Components

Workers compensation insurance premiums are calculated based on several factors. The primary factors are:

Base rate: the starting point in calculating premiums. The base rate or loss cost is filed by NCCI and all carriers are required to use it. The base rates can change annually due to statewide loss experience of all employers in the same classification. The companies multiply the base rate by their approved Loss Cost Multiplier (LCM) in order to determine the rate per $100 of payroll.

Classification: a key factor in determining what rate an employer will pay. Classification denotes the employer's type of business; hazardous jobs are more likely to result in substantial and costly claims and, therefore, usually have a higher rate. There are about 600 classifications in use in Kansas.

Experience rating: affects premium based on the frequency and severity of compensation claims of employers with sufficient premium size to be "experience rated." Currently, employers with an annual premium of at least $4,500 within the past two years, or if more than two years, an average annual premium of $2,250 or more are experience rated. Fewer and less expensive claims mean a lower experience modification factor, which means a lower premium.

Payroll size: employers with larger payrolls generate more workers compensation annual premiums than those with a smaller payroll in the same classification. However, the expenses incurred in issuing and servicing the policy do not increase in direct proportion to the policy premium. Consequently, a premium discount may be applied to policies with a larger premium to recognize this factor.

Also, some employers are subject to fixed payroll amounts. Partners, sole proprietors and members of a limited liability company who elect to cover themselves under a workers compensation insurance policy pay a premium based on a set payroll which is adjusted annually. The premium for an executive officer of a corporation is based on the actual payroll of the officer, subject to a set per-week minimum and maximum payroll which may be adjusted annually.

Factors Affecting Premiums

Three of the most important factors in reducing premiums are:

1. **Implementation of an accident prevention program:** these programs were mandated by 1993 legislation and are to be made available to employers by all insurance carriers and group-funded pools operating in Kansas. Because accident prevention programs have been shown to reduce the frequency and severity of injuries, they offer employers the potential to reduce premiums. Premium reduction is, of course, only one benefit of accident prevention that employers should consider.
2. **Assuring the proper classification(s) was used to calculate the premium:** the classification used on the policy should, as reasonably and accurately as possible, describe the employer's business and the employee's duties. The use of an inappropriate classification could result in the payment of an incorrect premium. If a classification does not seem to accurately describe a particular job, assistance in verifying that the proper classification was used or in obtaining a correction is available by calling the Insurance Department: (800) 432-2484 or (785) 296-3071, or visiting the website at www.ksinsurance.org.
3. **Use of deductible:** deductibles can be a cost-effective means of reducing premiums and are available in various amounts. Losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification. The insurer shall pay the deductible amount and seek reimbursement from the insured employer for the applicable deductible amount.

General Information

How to Obtain Insurance

Workers compensation insurance coverage can be obtained by:

- contacting a licensed insurance agent;
- contacting the Kansas Insurance Department for information on group-funded pools; or
- contacting the Division of Workers Compensation for information on self-insurance.

Kansas Workers Compensation Insurance Plan (Assigned Risk Plan)

Any employer who is in good faith entitled to but unable to purchase coverage in the voluntary workers compensation insurance market can obtain coverage in the Assigned Risk Plan. This means an employer is assigned to an insurance carrier who is authorized to provide coverage. Assigned Risk Plan premiums are calculated using the same loss costs as if the coverage were purchased in the voluntary market; however, premiums may be higher due to differentials applied to assigned risk rates and individual employer loss experience.

For assistance and questions about the Assigned Risk Plan, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Insurance Rating Appeals Process

If an employer suspects the wrong classification or other incorrect factor is being used in calculating a premium, the rating may be appealed in writing to the insurance carrier from which the coverage was purchased. The employer may also appeal in writing to the Kansas Commissioner of Insurance by outlining the nature of the complaint or appeal.

For additional information, or for assistance in appealing or correcting a classification error or other rate problem, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Division of Responsibilities

Responsibilities of the Employee:

- Notify your employer immediately. Per K.S.A. 44-520, for injuries on or after May 15, 2011, and before April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
  - 30 calendar days from the date of accident or the date of injury by repetitive trauma;
  - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
  - 20 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Per K.S.A. 44-520, for injuries on or after April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
  - 20 calendar days from the date of accident or the date of injury by repetitive trauma;
  - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
  - 10 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.
- Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.
- The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the Workers Compensation Act or has suffered a work-related injury.

Responsibilities of the Employer:

- Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.
- Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which

the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at 785-296-4000 or 800-332-0353. You may access our website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

- **The employer is required** by K.S.A. 44-5, 102(a) to deliver information immediately to employee or legal beneficiary to assist in the claims process (material is available from the employer's carrier or the Division of Workers Compensation), including form K-WC 27-A or K-WC 270-A (Spanish).

Responsibilities of the Division of Workers Compensation:

- Makes official record of accident reports filed with the division.

Survivors' Benefits

The workers compensation law provides for survivors' benefits in the event of an employee's job-related death. Survivors do not need to be U.S. citizens or reside in the United States to receive compensation.

The weekly benefits are based on 66.67 percent of the employee's average weekly wage at the time of the accident or injury, but cannot exceed the statutory **maximum**. The **minimum** death benefit is 50 percent of the state's average weekly wage in effect on the date of accident. Total compensation benefits may not exceed $300,000, unless benefits are being paid to a dependent child under the age of 18. Funeral expenses up to $5,000 and all medical and hospital expenses related to the fatal injury are also covered.

An initial payment of $40,000 must be made to the surviving legal spouse or wholly dependent child(ren) or divided among them, 50 percent to the surviving legal spouse and 50 percent to the dependent children. This $40,000 payment is not subject to the eight percent discount normally allowed for lump sum payments. The initial payment shall be paid immediately.

Spouse and Children

If an employee is survived by a spouse but no dependent children, the spouse receives the entire weekly benefit. If an employee is survived by a spouse and children, the weekly benefit is paid half to the spouse and half to the children. If an employee is survived only by children, the weekly benefit is divided equally among the children.

Dependent children receive benefits until age 18, or until age 23 if they are full-time students or mentally or physically disabled, even if the benefits exceed the statutory limit at the time of the accident. Where required, the employer shall pay the costs of a court appointed conservator not to exceed $1,000.

Other Dependents

If survivors' benefits are paid to the spouse and/or children, they may not be paid to any other beneficiaries. In the case of unmarried employees leaving no dependent children, any other dependents who were wholly or partially dependent upon the employee may receive compensation.

Dependents other than spouse or children may collect weekly benefits subject to the maximum of $18,500, until they die, remarry or receive more than 50 percent of their support from another source.

Legal Heirs

If the employee leaves no spouse, dependent children or other dependents either wholly or partially dependent upon the employee, a lump sum payment of $25,000 shall be made to the legal heirs of the employee.

Conditions Affecting Benefits

Drugs and Alcohol

An employer is not liable for workers compensation benefits if an employee is impaired due to the use of alcohol* or drugs** and the impairment contributed to injury or death. This includes the use of prescription or non-prescription medications; benefits may be allowed, however, if:

- the drugs or medications were taken in therapeutic doses; and
- the employee had not been impaired on the job from such medications within the past 24 months.

If it is shown that the employee was impaired at the time of the injury, there shall be a rebuttable presumption that the accident, injury, disability or death was contributed to by such impairment.

An employee's refusal to submit to a chemical test at the request of the employer shall result in the forfeiture of benefits under the Workers Compensation Act if the employer had sufficient cause to suspect the use of alcohol or drugs by the claimant, or if the employer's policy clearly authorizes post-injury testing.

The results of a chemical test shall be admissible evidence to prove impairment if the employer establishes that the testing was done under any of the following circumstances:

1. as a result of an employer-mandated drug testing policy, in place in writing prior to the date of accident or injury, requiring any worker to submit to testing for drugs or alcohol;
2. during an autopsy or in the normal course of medical treatment for reasons related to the health and welfare of the injured worker and not at the direction of the employer;
3. the worker, prior to the date and time of the accident or injury, gave written consent to the employer that the worker would voluntarily submit to a chemical test for drugs or alcohol following any accident or injury;
4. the worker voluntarily agrees to submit to a chemical test for drugs or alcohol following any accident or injury; or
5. as a result of federal or state law, or a federal or state rule or regulation having the force and effect of law, requiring a post-injury testing program and such required program was properly implemented at the time of testing.

*An employee is considered to be impaired from alcohol if the blood alcohol concentration at the time of injury is .04 or more.

** Confirmatory test cutoff levels (ng/ml)

- Marijuana metabolite..... 15
- Cocaine metabolite.....150
- Amphetamines:
  - Amphetamine.....500
  - Methamphetamine.....500
- Opiates:
  - Morphine 2000
  - Codeine.....2000
  - 6-Acetylmorphine.....10ng/ml
- Phencyclidine 25

Safety Violations: K.S.A. 44-501(a)(1)

Compensation for an injury shall be disallowed if such injury to the employee results from:

1. the employee's deliberate intention to cause such injury;
2. the employee's willful failure to use a guard or protection against accident or injury which is required pursuant to any statutes and provided for the employee;
3. the employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer;
4. the employee's reckless violation of their employer's workplace safety rules or regulations; or
5. the employee's voluntary participation in fighting or horseplay with a co-worker for any reason, work related or otherwise.

The preceding shall not apply when it was reasonable under the totality of the circumstances to not use such equipment, or if the employer approved the work engaged in at the time of an accident or injury to be performed without such equipment.

Coronary Disease and Stroke

The law does not provide compensation for coronary or coronary artery disease or cerebrovascular injury (e.g., stroke), unless it is shown that the exertion of the work that caused the injury was beyond that required by the employee's usual job duties. Another exception is vascular injury caused by extreme heat.

Prior Disability Ratings/Pre-existing Condition

Compensation for any permanent disability may be reduced by the existence of a rating on any applicable pre-existing disability.

K.S.A. 44-501(e): An award of compensation for permanent partial impairment, work disability or permanent total disability shall be reduced by the amount of functional impairment determined to be pre-existing. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

K.S.A. 44-501(e)(1): Where workers compensation benefits have previously been awarded through settlement or judicial administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be pre-existing. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of pre-existing functional impairment shall be established by competent evidence.

Guidelines for Obtaining Medical Treatment

Who Pays?

Employers are responsible for all medical treatment necessitated by a job-related injury or disease. This includes:

- services of a licensed health care provider;
- surgical, hospital and other medical treatment;
- medications, medical and surgical supplies;
- nursing services;
- crutches and other medical apparatus;
- ambulance services; and
- transportation between the employee's home and the place of medical treatment, subject to a minimum of five miles round trip.

If an employer has workers compensation insurance, the insurance carrier is required to pay for applicable medical expenses. Uninsured employers subject to workers compensation laws are still responsible for the medical bills of covered employees.

Employers are legally entitled to choose the treating physician. If an employee self-selects a physician who is not authorized or agreed upon by the employer, the employer is responsible for only the first $500 in medical bills from such self-selected physicians.

Employer-Ordered Examinations

After obtaining whatever emergency medical care is necessary, an employee shall submit to any reasonable physical examination ordered by the employer. The employer can also require the employee to submit to ongoing examinations – up to twice monthly, or more often if specifically ordered by the Division of Workers Compensation. Employees may forfeit the benefits that are available if they refuse to submit to such examinations. Employees are entitled to know the results of any physical examination ordered by the employer. At the employee's request, the doctor conducting the examination must furnish the employee, within a reasonable time after the examination, a report identical to that sent to the employer or the employer's carrier. Employees are entitled to have their own doctor present at, and participate in, any medical examination ordered by the employer. If this is not allowed, or if employees are not furnished a copy of the medical report, then the examination ordered by the employer will not be allowed as evidence related to the claim.

Fraud and Abuse

Both the Division of Workers Compensation and the Kansas Insurance Department have units dedicated to the investigation of fraudulent or abusive acts and practices that occur with regard to the Workers Compensation Act. Acts or conduct that are considered to be fraudulent or abusive can generally be described as situations in which claimants, employers or companies fail or refuse to follow directives of the Workers Compensation Act. The Workers Compensation Act applies to the following:

- persons claiming benefits under the Workers Compensation Act;
- employers subject to the requirements of the Workers Compensation Act;
- insurance carriers and group-funded self-insurance plans providing coverage for work-related injuries;
- any person, corporation, business or health care facility providing treatment for work-related injuries

- attorneys and other representatives of employers, employees, insurers or other entities involved in the administration of the Workers Compensation Act.

If the director, or the assistant attorney general assigned to the Division of Workers Compensation, has probable cause to believe a fraudulent or abusive act or practice that violates the Workers Compensation Act has occurred, a copy of any order and all investigative reports and any evidence in the possession of the Division of Workers Compensation which relates to such act shall be forwarded to the prosecuting attorney of the county in which the act occurred.

Any person who believes a violation of the Workers Compensation Act has occurred may notify the Division of Workers Compensation immediately and should send the information relating to the alleged violation to the division. The director shall evaluate the facts surrounding the alleged violation to determine the extent, if any, to which violations of the Workers Compensation Act exist. For more information, call (785) 296-4000 or (800) 332-0353; or send email to wcfraud@dol.ks.gov.

Any person who has a complaint against an insurance company, or other person/entity regulated by the Kansas Insurance Department, regarding the handling of a workers compensation claim, should contact the Anti-Fraud Division at the Kansas Insurance Department. Complaints may be made by calling (800) 432-2484 or (785) 296-3071, in writing by sending information to the Anti-Fraud Division at 420 SW 9th, Topeka, KS 66612 or online at www.ksinsurance.org.

Coverage and Compliance

The Compliance section monitors and assists employers to ensure that they fulfill two requirements under the Workers Compensation Act:

1. to secure workers compensation benefits for employees and
2. to file written reports of alleged work accidents.

Failure to secure workers compensation benefits or report accidents can result in monetary penalties against the employer. Failure to secure workers compensation benefits can also result in closure of the business.

Per K.S.A. 44-557, “it is...the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.”

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014 is outlined in KA.R. 51-9-17.

When the director has reason to believe an employer has engaged in the knowing and intentional failure to secure the payment of workers compensation to its employees, the director shall issue and serve upon such employer a statement of the charges and shall conduct a hearing in accordance with the Kansas Administrative Procedure Act. The employer may be liable to the state for a civil penalty in an amount equal to twice the annual premium or $25,000, whichever amount is greater.

The director shall order employers to come under the Workers Compensation Act by:

1. insuring and keeping insured the payment of such compensation with an insurance carrier authorized to transact the business of workers compensation insurance in the state of Kansas;
2. showing to the director that the employer carries such employer's own risk and is what is known as a self-insurer and by furnishing proof to the director of the employer's financial ability to pay such compensation for the employer's self; or
3. maintaining a membership in a qualified group-funded workers compensation pool. The cost of carrying such insurance or risk shall be paid by the employer and not the employee.

For more information, call (785) 296-4000 or (800) 332-0353; or send email to wccompliance@dol.ks.gov or go to www.dol.ks.gov.

Verify Coverage

You can check whether a business has workers compensation coverage online. The website provides public access to portions of the information reported by private workers compensation insurance carriers for use by the Kansas Department of Labor (KDOL). The accuracy of data from any third party cannot be guaranteed by the agency and KDOL is not responsible for the coverage information available through this link.

For additional help with verifying workers compensation coverage in Kansas, call Workers Compensation Coverage and Compliance at (785) 296-4000.

Safety and Health Services

Workplace safety and accident prevention is a key element of the law. This requirement was designed to reduce claims/losses which would hold down premiums for employers. Because rates are based on losses, the prevention of employee accidents through enhanced safety measures is one of the best ways employers can help keep rates down.

By law, insurance carriers and group-funded plans must provide accident prevention programs upon request to their insureds. Notice of such accident prevention programs must appear on the front page of every policy issued after July 1993.

Programs Offered by the Kansas Department of Labor

Consultation: offers assistance to private sector employers in safety and health program evaluations. Consultants offer advice in the recognition, evaluation and control of hazards in the workplace. Assistance with program initiation and development is available. Training, both formal and informal, is performed in all areas of safety and health. All services are at no cost to the client.

Public Sector Compliance: monitors the public sector – cities, counties, state agencies and school districts – by performing compliance audits under K.S.A. 44-636 and/or K.S.A. 44-575(f). Occupational hazards are identified and program elements are assessed. Hazards must be abated within 60 days. Investigations of employee complaints, near misses and fatalities are also conducted.

Accident Prevention: evaluates insurance companies and group-funded self-insurance plans to ensure that they are offering and providing safety and health services at no charge to their insureds as required by law. The quality and quantity of these services are evaluated by trained consultants by directly reviewing insurance company records and contacting those insured who have requested and been provided services. Accident prevention assistance is available by emailing AccidentPrevention@dol.ks.gov. You can also find information online at www.dol.ks.gov/Safety/accident.aspx.

Safety and Health Conference: the annual Kansas Safety and Health Conference brings industrial, academic, vendor and government safety representatives together. The conference is self-supporting and seeks to address the relevant safety issues in a variety of workshops and presentations.

Workplace safety and health assistance is available by calling (785) 296-4386 or by emailing indsafetyhealth@dol.ks.gov. You can also find information online under Workplace Safety at www.dol.ks.gov.

Ombudsman Services

The Kansas Division of Workers Compensation established a Claimant Advisory Section in 1978. In 1993 the Legislature followed a national trend and, by statute, created the ombudsman program. The workers compensation reform legislation of 1993 mandated an expanded role for the Claims Advisory Section to enable a more proactive approach to assisting all parties in understanding their rights and responsibilities under the Workers Compensation Act.

The division employs full-time personnel who specialize in aiding injured workers, employers and insurance professionals with claims information and problems arising from job-related injuries and illnesses. The ombudsman acts in an impartial manner and is available to provide the parties with information about the current issues within the workers compensation system. For example, the ombudsman has current information on legislative changes or changes due to decisions made by the Workers Compensation Board or the courts. The ombudsman section also can assist with specific issues on current workers compensation claims.

Assisting Injured Workers with:

- Providing general information
- Obtaining medical treatment
- Benefits not being paid or not being paid on a timely basis
- Unpaid medical benefits
- Calculations of benefits
- Timely notification of employer
- Procedures for filing for a hearing
- Obtaining survivors' benefits
- Informal dispute resolution
- Mediation assistance
- Interpretation for Spanish-speaking workers

Assisting Employers/Insurance Companies with:

- Providing general information
- Posting Workers Compensation Notice (K-WC 40-A)
- Providing required information to injured workers (K-WC 27-A or K-WC 270-A)
- Timely submission of accident reports

- Timely and appropriate payment of medical services
- Election information
- Assistance with death benefit requirements
- Informal dispute resolution
- Assistance with Spanish-speaking workers
- Employer staff training on workers compensation issues
- Site visits for hands-on assistance

Ombudsman assistance is available either in person or by calling (785) 296-4000 or (800) 332-0353. You also may send an email to wc@dol.ks.gov. Additionally, forms are available for download at www.dol.ks.gov.

Employer Services Unit
For technical assistance, and presentations and training for employers, call (785) 296-4000 or (800) 332-0353, or email wcemployerservices@dol.ks.gov.

Mediation

Mediation was legislatively created in 1996 (K.S.A. 44-5,117) and can be utilized at any point during the workers compensation process. The statute was amended in 1998 to allow mediation by video conferencing. Mediation is not mandatory or a prerequisite to a hearing and it may be utilized at any time during the worker compensation process. The issues that can be mediated are not restricted to medical or temporary total disability benefits.

What Is Mediation?

Mediation is a means of resolving disputes in an informal and non-adversarial atmosphere. The parties to a dispute use a neutral third party to facilitate the discussion. The mediator has no decision making authority or interest in the outcome to the dispute. The mediator's job is to assist the parties in identifying the issues in dispute and establishing common goals. The key to mediation is allowing the parties to work through their dispute and create their own agreements (self-determination).

Who Are the Mediators?

The mediators are employees of the Division of Workers Compensation who have received special training in the process of mediation. The mediators used by the Division of Workers Compensation meet or exceed the requirements established by K.S.A. 5-501 and amendments thereto, and any relevant rules of the Kansas Supreme Court as authorized pursuant to K.S.A. 5-510, and amendments thereto. Mediators receive training in conflict resolution techniques, neutrality, agreement writing, ethics, role playing, communication skills, evaluation of cases and the laws governing mediation.

Representation and Assistance

Any party may be represented by an attorney at this mediation conference or may request assistance from the Ombudsman/Claims Advisory section. The absence of an attorney during the process does not mean legal representation cannot be obtained later if the dispute is not settled in this informal setting.

For additional information or to schedule a mediation conference, please call (785) 296-4000 or (800) 332-0353. Write to Mediation Section, Kansas Department of Labor, Division of Workers Compensation, 401 SW. Topeka Blvd., Topeka, KS 66603-3182. You may send email to wcmediation@dol.ks.gov.

Medical Services

The primary function of the Medical Services section is the administration of the Schedule of Medical Fees. The fee schedule is updated and revised on an annual basis to promote health care cost containment, yet insure the availability of necessary treatment and care for injured employees.

The Medical Services section is available to act as a liaison between health care providers, employers, employees, insurance carriers, group-funded pools or self-insured businesses. Additionally, the section conducts informal hearings to assist in the resolution of disputed medical claims and related payments involving health care providers.

For assistance in resolving issues related to fee schedule interpretation, payment disputes, etc., contact the Medical Services section at (785) 296-4000 or fax (785) 296-0025.

Vocational Rehabilitation

Vocational rehabilitation may be provided at the option of the employer or the employer's insurance carrier. General experience has shown that the longer the length of time away from work recovering from an injury, the greater the likelihood that an employee will need vocational rehabilitation to resume suitable work at comparable pay.

If the employer or insurance carrier does not choose to provide for vocational rehabilitation, the employee can ask the rehabilitation administrator for a referral to a provider of such services, at the employee's expense. The employee can also request a referral to the Division of Rehabilitation Services in the Kansas Department for Children and Families.

For assistance with vocational rehabilitation, contact the rehabilitation administrator's office in the Division of Workers Compensation at (800) 332-0353 or (785) 296-4000 or send email to wcrehab@dol.ks.gov.

Kansas Department of Labor
Division of Workers Compensation

Kansas Department of Insurance

Kansas
Department of Labor

Información de Compensación de Trabajadores para Empleadores y Empleados del Estado de Kansas

K-WC 250 (5-15)

Copias de las formas de elección, reportes de accidente, exhibición de aviso (K-WC 40-A) y todos los demás carteles obligatorios están disponibles para descargarse en www.dol.ks.gov/WorkComp/frmpub2.aspx.

Para obtener información adicional sobre los beneficios de compensación de trabajadores, directrices para empleadores y otra información general, contacte:

Departamento de Laboral de Kansas
División de Compensación de Trabajadores
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603
(785) 296-4000
(800) 332-0353
Correo electrónico: wc@dol.ks.gov
Sitio en internet: www.dol.ks.gov

Síganos:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

Para más información en tarifas de seguro para compensación de trabajadores y conducta de compañías aseguradoras, contacte:

Departamento de Seguros de Kansas
420 S.W. 9th St.
Topeka, Kansas 66612-1678
(785) 296-3071
(800) 432-2484

Correo electrónico: commissioner@ksinsurance.org
Sitio en internet: www.ksinsurance.org

Índice

¿Qué es Compensación de Trabajadores?

Compensación de trabajadores es un plan de seguro requerido del empleador para pagar beneficios al empleado por lesiones relacionadas con el trabajo, incapacidad o muerte que surgen de y en el curso del empleo.

De acuerdo al artículo de ley K.S.A. 44-508, se considerará que una lesión por accidente surge del empleo si:

- Hay una conexión causal entre las condiciones bajo las cuales el trabajo es requerido a ser realizado y el accidente resultante; y
- El accidente es el factor predominante causando la lesión, condición médica y la resultante discapacidad o impedimento físico.

Las palabras "surgen de y en el curso del empleo" como se usan en la ley de compensación de trabajadores no se interpretarán para incluir:

- Lesión que se produjo como resultado del proceso de envejecimiento natural o por las actividades normales del vivir diario;
- Accidente o lesión que surgió de un riesgo neutral sin empleo particular o de carácter personal;
- Accidente o lesión que surgió de un riesgo personal para el trabajador; o
- Accidente o lesión que surgió directa o indirectamente por causas desconocidas.

Los beneficios son pagados a expensas del empleador. La cobertura empieza el primer día de trabajo.

La presente ley abarca todos los empleadores de Kansas excepto aquellos en ciertas actividades agrícolas o aquellos con una nómina anual bruta de 20,000 dólares o menos. Toda nómina es tomada en cuenta, incluyendo la que es pagada en Kansas o en otras partes. Si el empleador es un único propietario o una miembro de una asociación, los salarios pagados a los propietarios y a cualquiera de sus familiares no se utilizan en el cálculo de la nómina anual bruta. De acuerdo con K.A.R 51-11-6, la disposición en K.S.A. 44-505 excluyendo la nómina de trabajadores que son miembros de la familia del empresario no se aplicará a las corporaciones. La nómina de una corporación para el propósito de determinar si el empleador es sujeto a la ley de compensación del trabajadores o no, deberá ser determinada por la suma total de los sueldos pagados a los empleados corporativos incluso cuando un empleado de la corporación ha elegido no ser cubierto por la ley de compensación de los trabajadores en conformidad con K.S.A. 44-543.

Los empleados discapacitados debido a una enfermedad o lesión relacionada con el trabajo tienen derecho a:

- gastos médicos para tratar la lesión relacionada con el trabajo o la enfermedad; y
- beneficios de ingresos para sustituir parte del salario perdido debido a la discapacidad.

Si muerte resulta de una enfermedad o lesión relacionada con el trabajo, podrán pagarse beneficios al cónyuge sobreviviente, dependientes o herederos.

Propósito de la Ley

Kansas pasó su primera ley de compensación trabajadores en el año de 1911. Mediante la regulación de los litigios y los beneficios, la ley está diseñada para proteger los intereses de los empleadores y empleados. Los empleadores se benefician mediante sustituir un gasto conocido (primas) por el riesgo a largo plazo de gastos no presupuestados, en caso de discapacidad grave del empleado. Los empleados se benefician debido a que la negligencia del empleador no es una cuestión en la determinación de responsabilidad. Cobertura de compensación de trabajadores es un sistema sin culpa. Las disposiciones de la Ley de Compensación de Trabajadores se aplicarán imparcialmente a los empleadores y empleados. Aunque inicialmente la ley estaba destinada a trabajos peligrosos, ahora cubre a la mayoría de los trabajadores.

Elecciones

Elecciones dentro o fuera de la Ley de Compensación de Trabajadores son opciones disponibles para los empleadores o empleados. Dependiendo de las circunstancias, las opciones pueden estar disponibles para:

- empleadores no cubiertos: por ejemplo, aquellos con nóminas de 20,000 dólares o menos o en ciertas actividades agrícolas;
- empleados de una corporación dueños de 10 por ciento o más de las acciones;
- individuos, propietarios o asociaciones;
- empleadores buscando cobertura para voluntarios y otros trabajadores no cubiertos; y
- directores voluntarios, funcionarios o administradores de una organización sin fines de lucro.

Ejemplo: Una asociación de dos personas tiene dos empleados: un miembro de la familia y uno que no es miembro de la familia: y una nómina anual de 15,000 dólares. La asociación puede optar por adquirir la cobertura bajo la ley y extender dicha cobertura a ambos empleados. Los socios no están cubiertos porque son considerados como el empleador.

Formas de elección pueden encontrarse en el Internet en www.dol.ks.gov.

Derechos y Responsabilidades de los Empleados

La Ley del estado de Kansas protege el derecho del empleado y facilita la obtención de compensación del trabajador. Específicamente:

- Un empleado no puede ser despedido, degradado o discriminado de cualquier otra manera por la presentación de un reclamo en buena fe.
- Los empleados deben ser informados de sus derechos y responsabilidades en caso de lesión. En el caso de muerte del empleado, dicha información deberá aportarse a los beneficiarios del empleado.
- No se debe imponer un pago a los empleados para reclamos de compensación de trabajadores. Los empleadores no puede deducir del sueldo o de los beneficios para pagar las primas de seguros o reclamos.
- Empleados pueden tener derecho a beneficios de compensación de un empleador sujeto a la Ley independientemente de la cobertura del seguro.
- Empleados pueden obtener asistencia gratuita mediante ponerse en contacto con la oficina Ombudsman de Compensación de Trabajadores a los teléfonos (800) 332-0353 o (785) 296-4000.
- La ley estipula sanciones específicas por fraude tanto a empleados como empleadores en casos de compensación de trabajadores. Para más información o asistencia, o para reportar sospecha de fraude, póngase en contacto con la Oficina Ombudsman de Compensación de Trabajadores o la Oficina de Fraude y Abuso a los teléfonos (785) 296-4000 o (800) 332-0353.

Responsabilidades del Empleador

Seguro de Compensación para Trabajadores

La mayoría de los empleadores están obligados por ley a proveer el pago de reclamos de compensación de trabajadores, sin ningún costo para el empleado. Los empleadores deberán cumplir con este requisito de tres maneras:

- Seguro de compensación de trabajadores: obtenido de una compañía de seguros con licencia; el empleador paga las primas y la compañía de seguros paga los reclamos. Las compañías de seguros son reguladas por el Departamento de Seguros del estado de Kansas.
- Auto-seguro: un empresario individual debe demostrar al Estado de Kansas la capacidad financiera para pagar cualquier reclamo que pudiera surgir. Este programa es administrado por la División de Compensación de Trabajadores.
- Grupo financiero de fondo común: un grupo de empresarios que cumplen ciertos requisitos legales pueden formar un programa de auto-seguro para asegurar conjuntamente su capacidad para pagar los reclamos. Este programa es administrado por el Departamento de Seguros del estado de Kansas.
- Falta deliberada de proveer el pago de compensación de trabajadores en una de las formas anteriores es un delito menor, clase A y somete al empleador a una pena civil en una cantidad dos veces la prima anual que el empleador hubiera pagado por seguro o 25,000 dólares, cualquiera de las cantidades que sea mayor.

Categorías de empleo excluidos de la ley son:

- ciertas actividades agrícolas;
- agentes inmobiliarios que califican como contratistas independientes;
- empleadores con nóminas anuales brutas de 20,000 dólares o menos;
- bomberos pertenecientes a una asociación de socorro de bomberos que ha renunciado la cobertura bajo la Ley de Compensación de los Trabajadores; y
- ciertos conductores de vehículos que son propietarios y que están cubiertos por su propia póliza de seguro de accidente laboral.

Otros Requisitos

- Los empleadores deben exponer el aviso escrito (K-WC 40-A), comunicando a los empleados qué hacer en caso de un accidente.
- De acuerdo con la ley K.S.A. 44-557, *es...la responsabilidad de cada empleador de hacer o causar que se haga un reporte a el director* de cualquier accidente, reclamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones.*
- Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en:http://www.dol.ks.gov/WorkComp/edinews.aspx.
- **Inmediatamente al enterarse de la lesión o la muerte de un empleado, el empleador deberá suministrar información por escrito al empleado o a los dependientes del empleado sobre los beneficios disponibles, el proceso de reclamo, el empleador o compañía de seguros de contacto para reclamos de compensación de trabajadores y otros asuntos como es requerido por la ley.** Las formas K-WC 27-A y K-WC 270-A (en español) está disponibles en internet, en el sito de la División de Compensación de Trabajadores en:www.dol.ks.gov/WorkComp/frmpub2.aspx.
- Un empleador con seguro o auto-asegurado deberá suministrar el siguiente aviso a un trabajador asegurado o con el primer cheque de beneficios de incapacidad temporal: *Advertencia: aceptación de empleo con un empleador diferente que requiere la realización de actividades que usted ha declarado que no puede realizar debido a la lesión por la que está recibiendo beneficios de incapacidad temporal puede constituir fraude y podría resultar en pérdida de beneficios en el futuro y la restitución de previas indemnizaciones y beneficios pagados.*

Si necesita ayuda, llame a (800) 332-0353 o (785) 296-4000.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A.R. 51-9-17.

Categorías de Beneficios por Incapacidad

Incapacidad Total Temporal

Existe cuando el empleado, a causa de una lastimadura, no ha podido participar en cualquier tipo de empleo sustancial y remunerativo. Beneficios son pagados por la duración de la incapacidad temporal total (TTD por sus siglas en inglés). Existe un período de espera de una semana (siete días consecutivos) antes de que los beneficios temporales (TTD) sean pagados. Si la discapacidad continúa por tres semanas consecutivas, el empleado es reembolsado por el período de espera. Empleados pueden obtener beneficios médicos durante la primera semana. Los beneficios temporales son 66.67 por ciento del promedio del sueldo semanal bruto del empleado, pero no menos de 25 dólares ni más que el máximo legal vigente. La compensación total no debe exceder de 130,000 dólares por lesión.

Los empleados no podrán cobrar beneficios de incapacidad total temporal y beneficios de desempleo por las mismas semanas.

Incapacidad Parcial Temporal

Existe cuando el trabajador regresa a cualquier clase de empleo ganando un sueldo inferior a aquel que tenía al tiempo de lesionarse. La compensación es calculada sobre una base semanal y se paga hasta que no hay más pérdida del sueldo o hasta que el máximo beneficio es alcanzado, lo que ocurra primero.

Los beneficios son 66.67 por ciento de la diferencia entre el salario promedio bruto semanal del empleado antes de la lesión y el salario del empleado después de la lesión pero no pueden exceder el máximo legal vigente en el estado.

Incapacidad Parcial Permanente

Existe cuando hay pérdida total o parcial del uso de una parte del cuerpo, como un brazo, debido a una lesión relacionada con el trabajo. Compensación para una incapacidad parcial permanente se limita a un porcentaje de la tabla siguiente. Un período de curación está disponible en los casos de amputación.
Los beneficios son 66.67 por ciento de un salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal de 130,000 dólares.

Lista de información de beneficios

Pérdida o pérdida del uso de:	semanas pagadas:
Hombro	225
Brazo	210
Antebrazo	200
Mano	150
Pierna	200
Pierna inferior	190
Pie	125
Ojo	120
Oído (ambos)	110
Oído (uno solo)	30

Pérdida o pérdida del uso de:	semanas pagadas:
Dedo Pulgar	60
Dedo índice	37
Dedo medio	30
Dedo anular	20
Dedo meñique	15
Dedo gordo del pie	30
Dedo gordo del pie (articulación de la punta)	15
Cada dedo del pie	10
Cada dedo del pie (articulación de la punta)	5

Incapacidad General Parcial Permanente

Existe cuando un empleado se ha incapacitado de tal manera que es de carácter parcial y de calidad permanente y que no está cubierto por lo enlistado anterior. Por ejemplo, discapacidad envolviendo la espalda o la pérdida del uso de un hombro, brazo, antebrazo o mano, de una extremidad superior, combinada con la pérdida o pérdida uso de un hombro, brazo, antebrazo o mano, de la otra extremidad superior; o la pérdida o pérdida de uso de una pierna, pierna baja o pie, de una extremidad inferior, combinado con la pérdida de o pérdida del uso de una pierna, pierna baja o pie, de la otra extremidad

inferior; o la pérdida de o pérdida del uso de ambos ojos que es parcial en carácter y permanente en calidad son discapacidades de todo el cuerpo y no están cubiertos por la lista anterior. Compensación por tales discapacidades "no programadas" o "cuerpo entero" se basa en el mayor de lo siguiente: el porcentaje de impedimento funcional; o la capacidad reducida del empleado para realizar tareas de trabajo y el sueldo semanal promedio que empleado es capaz de ganar después de la lesión. Empleados ganando 90 por ciento del sueldo que tenían antes de la lesión están limitados a impedimento funcional.

Calculando beneficios de incapacidad general parcial permanente

1. Cálculo el porcentaje de beneficio semanal mediante la identificación de la menor de estas dos cantidades: Sueldo promedio semanal bruto x 66.67 por ciento; o el máximo legal vigente.
2. Cálculo de las semanas de compensación permitidas: se empieza con 415 semanas. De las 415, se restan las semanas en que se pagó incapacidad total temporal, excluyendo las primeras 15 semanas de TTD. Se multiplica la diferencia por el porcentaje de incapacidad.
3. Cálculo del total de los beneficios: Se multiplican los beneficios semanales por el número de semanas de compensación permitidas.

Ejemplo: El sueldo promedio semanal es 875 dólares en la fecha del accidente (10/07/2011). El empleado ha cobrado 25 semanas de incapacidad total temporal (TTD) y tiene una un porcentaje de incapacidad del 25 por ciento.

Beneficio semanal: (utilice la cantidad menor)
$875 x .6667 = $583.36
Máximo legal (a partir del 07/01/11) $555

Semanas de compensación permitidas:
415 - [25-15] = 415 - 10 = 405 semanas
405 semanas x .25 = 101.25 semanas

Cantidad de beneficio máximo:
101.25 semanas x $555 = $56,193.75

Nuestro sitio en Internet tiene un programa de cálculo de beneficios de compensación de trabajadores. El programa de fechas le permite calcular el tiempo entre dos fechas o para calcular la suma de días a una fecha conocida. Los programas de la lista de lesiones y lesiones del cuerpo entero le permitirán calcular los beneficios de compensación a la que tiene derecho el reclamante. Se proporcionan instrucciones paso a paso para cada programa.

Incapacidad Total Permanente

Existe cuando el empleado, a causa de la lesión, ha quedado completa y permanentemente incapaz de participar en cualquier tipo de empleo remunerado y sustancial. Pérdida de ambos ojos, ambas manos, ambos brazos, ambos pies, ambas piernas o cualquier combinación de éstas, en ausencia de prueba de lo contrario, deberán constituir una incapacidad permanente total. Parálisis total considerable o imbecilidad incurable o locura, resultantes de lesiones independientes de todas las otras causas, también constituirán incapacidad total permanente.

Los beneficios son 66.67 por ciento del salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal. La compensación total no debe exceder 155,000 dólares por lesión.

Un empleado no puede recibir más de una indemnización de incapacidad total permanente en la vida.

Cómo se Determinan las Tasas de Interés

El seguro de compensación de trabajadores en Kansas es obligatorio por la ley estatal para la mayoría, pero no para todos los empleadores.

Las primas pagadas por los empleadores deberían ser suficientes para cubrir los reclamos incurridos por sus compañías de seguros. Las tasas de interés se ajustan en función de las primas más recientes, los ingresos de inversión y pérdidas reportadas por las compañías de seguros. El Consejo Nacional de Seguros Compensatorios (NCCI por sus siglas en inglés) presenta estas tasas de interés anualmente al Comisionado de Seguros para su aprobación.

El Consejo Nacional de Seguros Compensatorios (NCCI) es una organización clasificadora, autorizada por el departamento de seguros, cuya composición, primordialmente consta de compañías de seguros. Ellos desarrollan el cambio necesario de la tasa de interés anual basándose en las pérdidas y primas reportadas a ellos por las compañías de seguros miembros de dicha organización.

El Departamento de Seguros de Kansas regula las tarifas que se cobran en el estado. Cada año, éste Departamento revisa las primas, los costos de los reclamos y otros datos pertinentes presentados por el NCCI para determinar si se recomienda un cambio en la tasa de interés o no. Actualmente, alrededor de 70 centavos de cada dólare recogidos en el cobro de las primas, se proyecta para cubrir el costo de pagar reclamos de compensación de trabajadores. Aproximadamente 27.5 por ciento de cada dólar es utilizado por las compañías de seguros para cubrir otros costos de hacer negocios: por ejemplo, gastos administrativos, salarios y gastos generales. El margen de beneficio se proyecta en aproximadamente un 2.5 por ciento Además de las ganancias de las inversiones.

Después de revisar la presentación de la tasa de interés, el Comisionado de seguros generalmente aprueba un cambio “global” en la prima estatal. Este cambio "global" se expresa como un porcentaje (por ejemplo, un cinco por ciento de aumento global); Sin embargo, los tipos básicos de clasificación individual pueden aumentar o disminuir más del cambio "global." Los tipos básicos de clasificación individual deben continuar reflejando la experiencia (las primas y pérdidas) de los empleadores en cada clasificación.

Componentes de la Prima

Las primas de seguro de compensación de trabajadores se calculan basándose en varios factores. Los principales son:

Tasa de interés básica: el punto de partida para el cálculo de las primas. La tasa de interés o costo de pérdida es presentado por NCCI y todas las aseguradoras requeridas de usarla. Esta podría cambiar anualmente basada en la experiencia de la pérdida de otros empleadores en todo el estado en la misma clasificación. Las compañías multiplican la tasa de interés por su Multiplicador de Costo de pérdida aprobado para determinar la tasa de interés por cada 100 dólares de nómina.

Clasificación: un factor clave para determinar la tasa de interés que un empleador pagará. La clasificación denota la tipo de negocios; trabajos peligrosos tienen más probabilidades de provocar reclamos importantes y costosos y, por tanto, tienen una tasa de interés más alta. Hay unas 600 clasificaciones en uso en Kansas.

Clasificación basada en la experiencia: afecta la prima basada en la frecuencia y gravedad de los reclamos de compensación de los empleadores con tamaño de prima suficiente para ser "clasificados por experiencia." Actualmente, los empleadores con una prima anual de por lo menos 4,500 dólares en los últimos dos años, o si más de dos años, una prima promedio anual de 2,250 dólares o más son calificados de experiencia. Más pocos y menos costosos reclamos significan un factor modificación por riencia más bajo, lo que significa una prima menos costosa.

Tamaño de la nómina: los empleadores con grandes nóminas generan primas anuales de compensación de trabajadores mayores que aquellos con una nómina más pequeña en la misma clasificación. Sin embargo, los gastos de distribución y abastecimiento de la póliza no incrementa en proporción directa a la prima de la póliza. En consecuencia, un descuento en la prima puede aplicarse a las pólizas con una prima más grande para reconocer este factor.

También, algunos empleadores están sujetos a cantidades de nómina fija. Socios, propietarios y miembros de una compañía de responsabilidad limitada que eligen cubrirse bajo una póliza de seguro de compensación de trabajadores pagan una prima basada en una nómina fija la cual se ajusta anualmente. La prima para un funcionario ejecutivo de una empresa se basa en la nómina actual del oficial, sujeta a una nómina mínima y un máxima establecida por semana, la cual que puede ser ajustada anualmente.

Factores que Afectan a las Primas

Tres de los factores más importantes en la reducción de las primas son:

1. **Implementación de un programa de prevención de accidentes:** estos programas fueron ordenados por la legislatura de 1993 y están disponibles a los empleadores por todas las compañías de seguros y grupo financiado por un fondo común operando en Kansas. Porque los programas de prevención de accidentes han demostrado reducir la frecuencia y la gravedad de las lesiones, que ofrecen a los empleadores la posibilidad de reducir las primas. La reducción de la prima es, por supuesto, sólo uno de los beneficios de la prevención de accidentes que los empleadores deben tener en cuenta.
2. **Asegurándose que la(s) clasificación(es) adecuada(s) ha(n) sido usada(s) para calcular la prima:** la clasificación utilizada en la póliza debe describir, tan razonable y preciso como sea posible, el negocio del empleador y los deberes del empleado. El uso de una clasificación inadecuada puede resultar en pago de una prima incorrecta. Si la clasificación no parece describir con precisión un trabajo en particular, ayuda para verificar que se utilizó la clasificación adecuada o para obtener una corrección, está disponible llamando al Departamento de Seguros al teléfono: (800) 432-2484 o (785) 296-3071 o visitando el sitio en internet www.ksinsurance.org.
3. **Uso de deducible:** los deducibles pueden ser una manera efectiva de reducir las primas y están disponibles en diversas cantidades. No se aplicarán las pérdidas pagadas por el empleador bajo el deducible para calcular la modificación de la experiencia del empleador. El asegurador deberá pagar el importe de deducible y solicitar el reembolso del empleador asegurado por la cantidad del deducible aplicable.

Información General

Cómo Obtener un Seguro

Cobertura de seguro de compensación de trabajadores puede obtenerse por:

- ponerse en contacto con un agente de seguros con licencia;
- ponerse en contacto con el departamento de seguros de Kansas para obtener información sobre grupos financiados por el grupo; o
- ponerse en contacto con la División de compensación de trabajadores para obtener información sobre auto-seguro.

Plan de Seguro de Compensación para Trabajadores de Kansas (Plan de Riesgo Asignado)

Cualquier empresario que tenga derecho pero que no pueda adquirir cobertura en el mercado de seguros de indemnización de trabajadores voluntario, puede obtener cobertura en el Plan de riesgo Asignado. Esto significa que un empleador es asignado a una compañía de seguros que está autorizada para proporcionar cobertura.

Las primas para el Plan de Riesgo Asignado se calculan utilizando los mismos costos de pérdida como si la cobertura hubiese sido comprada en el mercado voluntario; sin embargo, las primas pueden ser mayores debido a recargos adicionales que se basan en la tamaño del empleador de prima y pérdida de experiencia.

Para asistencia y preguntas relacionadas al Plan de Riesgo Asignado llame al Departamento de Seguros del estado de Kansas a los teléfonos (800) 432-2484 o (785) 296-3071.

Proceso de Apelación de Clasificación de Seguro

Si un empleador sospecha de una clasificación errónea u que otro factor incorrecto has sido utilizado para calcular una prima, la clasificación puede ser apelada por escrito a la compañía de seguros de la que se obtuvo la cobertura. El empleador también puede apelar por escrito al Comisionado de Seguros del estado de Kansas resumiendo la naturaleza de la queja o apelación.

Para información adicional o asistencia para apelar o corregir un error de clasificación u otro problema de clasificación, comuníquese con el Departamento de Seguros de Kansas al (800) 432-2484 o (785) 296-3071.

División de Responsabilidades

Responsabilidades del Empleado:

Notificar al empleador inmediatamente. De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Mayo 15, 2011, y antes de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 30 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 20 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 20 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 10 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

El aviso podrá darse verbalmente o por escrito. Donde el aviso se proporciona oralmente, si el empleador tiene designado a un individuo o departamento a quien debe darse el aviso y tal designación ha se ha comunicada por escrito al empleado, aviso a cualquier otra persona o departamento será insuficiente en esta sección. Si el empleador no ha designado a un individuo o departamento a quien debe darse aviso, el aviso debe proporcionarse a un administrador o supervisor.

Donde el aviso es provisto por escrito, aviso debe enviarse a un supervisor o gerente en la ubicación principal de trabajo del empleado.

El aviso, ya sea que se suministre oralmente o por escrito, deberá incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser evidente a partir del contenido del aviso de que el empleado está cobrando beneficios bajo la Ley de Compensación de Trabajadores o ha sufrido una lesión relacionada con el trabajo.

Responsabilidades del Empleador:

- A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero con fondos en común de la lesión del empleado.
- El empleador/compañía aseguradora debe presentar un informe de accidente con la división dentro de 28 días a partir de la fecha de conocimiento del empleador acerca de la lesión.
- El empleador es requerido por el artículo de ley, K.S.A. 44-5, 102(a) para entregar información al empleado o beneficiario legal inmediatamente para ayudar en el proceso de reclamos (material está disponible con la compañía aseguradora del empleador o en la División de Compensación de Trabajadores), incluyendo el formulario K-WC 27-A o K-WC 270-A (español).

Responsabilidades del División de compensación de trabajadores:

- Hace el registro oficial de informes de accidentes presentados ante la División.

Beneficios para los Sobrevivientes

La ley de compensación de los trabajadores provee beneficios para sobrevivientes en caso de fallecimiento relacionado con el trabajo. Los sobrevivientes no necesitan ser ciudadanos estadounidenses o residir en los Estados Unidos para recibir compensación.

Los beneficios semanales se basan en el 66.67 por ciento del salario semanal promedio del empleado en el momento del accidente o lesión, pero no pueden exceder el **máximo** legal. El beneficio de fallecimiento mínimo es de 50 por ciento del salario semanal promedio del Estado en vigor en la fecha del accidente. Los beneficios de compensación total no puede exceder la cantidad de 300,000 dólares, a menos que se les esté pagando beneficios a dependientes menores de 18 años. Los gastos de funeral hasta 5,000 dólares, así como todos los gastos médicos y de hospital relacionados con la lesión fatal también son cubiertos.

Un pago inicial de 40,000 dólares debe ser hecho al cónyuge legal sobreviviente o niño(s) completamente dependientes o dividido entre ellos, un 50 por ciento para el cónyuge legal y 50 por ciento al (los) niño(s) dependiente(s). Este pago de 40,000 dólares no está sujeto al ocho por ciento de descuento que normalmente es permitido en los pagos globales. El pago inicial deberá ser pagado inmediatamente.

Cónyuge e Hijos

Si un empleado es sobrevivido por un cónyuge pero sin hijos dependientes, el cónyuge recibe todo el beneficio semanal. Si un empleado es sobrevivido por un cónyuge e hijos dependientes, el beneficio semanal es pagado la mitad el cónyuge, y la otra mitad a los hijos dependientes. Si un empleado es sobrevivido solo por los hijos dependientes, el beneficio semanal es dividido en partes iguales entre los hijos.

Los hijos dependientes reciben beneficios hasta la edad de 18 años, o hasta la edad de 23 años si son estudiantes de tiempo completo o están mental o físicamente discapacitados, incluso si los beneficios superan el límite legal en el momento de la accidente. Donde es requerido, el empleador deberá pagar los costos de un conservador nombrado por un tribunal sin exceder la cantidad de 1,000 dólares.

Otros Dependientes

Si los beneficios de sobrevivientes son pagados al cónyuge y/o a los hijos dependientes, no pueden ser pagados a cualquier otro beneficiario. En el caso de un empleado soltero sin hijos dependientes, otro beneficiario, dependiente total o parcialmente del empleado puede recibir la compensación.

Los dependientes que no sean el cónyuge o hijos dependientes pueden percibir los beneficios semanales hasta un máximo de 18,500 dólares, o hasta que fallezcan, se casen o reciban más del 50 de su sustento de otra fuente.

Herederos Legales

Si el empleado no deja cónyuge, hijos dependientes u otros beneficiarios ya sea total o parcialmente dependientes del empleado, un pago único de 25,000 dólares deberá ser hecho a los herederos legales del empleado.

Condiciones que Afectan los Beneficios

Alcohol y Estupefacientes

Un empleador no es responsable de beneficios de compensación de trabajadores si un empleado está incapacitado debido al uso de alcohol* o estupefacientes** y la incapacidad contribuyó a la lesión o fallecimiento. Esto incluye el uso de medicamentos con o sin receta médica; sin embargo, los beneficios pueden ser permitidos, si:

- los fármacos o medicamentos fueron tomados en dosis terapéuticas; y
- el empleado no estado incapacitado en el trabajo por dichos medicamentos en los últimos 24 meses.

Si se demuestra que el empleado estaba incapacitado en el momento de la lesión, deberá haber una presunción refutable de que el accidente, lesiones, discapacidad o fallecimiento fueron contribuidos por dicha deficiencia.

Si el empleado rehúsa someterse a un examen químico a petición del empleador resultará en pérdida del derecho de beneficios bajo la ley de compensación de trabajadores, si el empleador tuviera suficientes motivos para sospechar el uso de alcohol o estupefacientes por el reclamante, o si la póliza del empleador autoriza claramente las pruebas después de una lesión.

Los resultados del examen químico deberán ser evidencia admisible para demostrar la incapacidad si el empleador establece que el examen se realizó bajo cualquiera de las siguientes circunstancias:

1. como resultado de una póliza del empleador por escrito, donde es obligatorio el examen para uso de estupefacientes, establecida antes de la fecha del accidente o lesión, requiriendo a cualquier trabajador que se someta a exámenes de estupefacientes o alcohol;
2. durante una autopsia o en el curso normal de tratamiento médico por motivos relacionados con la salud y el bienestar del trabajador lesionado y no a dirección del empleador;
3. el trabajador, antes de la fecha y hora del accidente o lesión, dio el consentimiento por escrito al empleador de que el trabajador se sometería voluntariamente a un examen químico de estupefacientes o alcohol seguido de cualquier accidente o lesión;
4. el trabajador acepta voluntariamente someterse a un examen químico de estupefacientes o alcohol después de cualquier accidente o lesión; o
5. como resultado de la ley federal o estatal, o norma federal o estatal o una regulación teniendo la fuerza y efecto de la ley, requiriendo un programa de pruebas después de la lesión y dicho programa requerido fue correctamente implementado en el momento de la prueba.

*Un empleado es considerado de estar incapacitado por uso de alcohol si la concentración de alcohol en la sangre es de 0.04 o más en el momento de la lesión.

** Niveles límite de prueba confirmatoria (ng/ml)

Marihuana metabólica..... 15
Cocaína metabólica.....150
Anfetaminas:
Anfetamina.....500
Metanfetamina.....500

Opiáceos:
Morfina.....2000
Codeína.....2000
6-Acetylmorphine.....10ng/ml
Phencyclidine 25

Violaciones de Seguridad: K.S.A. 44-501(a) (1)

Compensación por una lesión deberá ser desaprobada si dicha lesión al empleado es el resultado de:

1. la intención deliberada del empleado de causar dichas lesiones;
2. falta intencionada del empleado de no utilizar una guarnición o protección contra accidentes o lesiones que es requerida en conformidad con cualquier estatuto y proporcionadas para el empleado;
3. falta intencionada del empleado para utilizar una razonable y adecuada guarnición y protección voluntariamente provista al empleado por el empleador;
4. violación de descuido del empleado de las normas o reglamentos de seguridad de su empleador o;
5. la participación voluntaria del empleado en peleas o bromas con un compañero de trabajo por cualquier motivo, relacionado con el trabajo o de otro tipo.

Lo anterior no deberá aplicar cuando era razonable bajo la totalidad de las circunstancias para no utilizar dicho equipo, o si el empleador aprobó en el trabajo comprometido en el momento de un accidente o lesión para ser realizado sin dicho equipo.

Enfermedad Coronaria y Derrame Cerebral

La ley no provee compensación por coronaria o enfermedad de la arteria coronaria o lesión cerebrovascular (por ejemplo, derrame cerebral), a menos que se demuestre que el esfuerzo del trabajo que causó la lesión fue más allá de lo requerido por el trabajo habitual del empleado. Otra excepción es la lesión vascular causada por temperaturas extremas.

Previa Clasificación de Incapacidad/Condición Pre-existente

Compensación por cualquier incapacidad permanente puede ser reducida por la existencia de una clasificación en cualquier incapacidad pre-existente aplicable.

K.S.A. 44-501(e): una adjudicación de compensación por incapacidad parcial permanente, incapacidad de trabajo o incapacidad total permanente deberá ser reducida por la cantidad de incapacidad funcional determinada a ser preexistente. Cualquier mencionada reducción no deberá aplicar a incapacidad total temporal, ni deberá aplicar a compensación por tratamiento médico.

K.S.A. 44-501(e)(1): donde beneficios de compensación de trabajadores han sido adjudicados previamente a través de un acuerdo o una determinación judicial administrativa en Kansas, las bases del porcentaje de previo acuerdo o adjudicación deberá establecer conclusivamente la cantidad de incapacidad funcional determinada a ser preexistente. Donde beneficios de compensación de los trabajadores no han sido previamente adjudicados a través de un acuerdo o determinación judicial o administrativa en Kansas, la cantidad de incapacidad funcional preexistente deberá ser establecida por evidencia competente.

Directrices para Obtener Tratamiento Médico

¿Quién Paga?

Los empleadores son responsables de todo tratamiento médico necesitado para una lesión o enfermedad relacionada con el trabajo. Esto incluye:

- servicios de un médico profesional con licencia;
- cirugías, hospital y otros tratamientos médicos;
- medicamentos, médicos y quirúrgicos suministrados;
- servicios de enfermería;
- muletas y otros aparatos médicos;
- servicios de ambulancia; y
- transporte entre el domicilio del empleado y el lugar de tratamiento médico, sujeto a un mínimo de cinco millas de viaje redondo.

Si un empleador tiene seguro de compensación de trabajadores, la compañía de seguros es requerida a pagar por gastos médicos aplicables. Los empleadores no asegurados sujetos a las leyes de compensación de trabajadores siguen siendo responsables de las facturas médicas de los trabajadores cubiertos.

Los empleadores tienen el derecho legal de elegir al médico del tratamiento. Si un empleado selecciona por sí mismo a un médico no autorizado o que no ha sido acordado con el empleador, el empleador es responsable solamente por los primeros 500 dólares en facturas médicas de dichos médicos seleccionados por el empleado.

Exámenes Ordenados por el Empleador

Después de obtener cualquier atención médica de emergencia necesaria, el empleado deberá someterse a cualquier examen físico razonable ordenado por el empleador. El empleador también puede requerir que el empleado se someta a exámenes de continuo – hasta dos veces al mes, o más seguido si es específicamente ordenado por la División de Compensación de Trabajadores. Los empleados pueden perder su derecho a beneficios que están disponibles si se niegan a someterse a dichos exámenes. Los empleados tienen derecho a conocer los resultados de cualquier examen físico ordenado por el empleador. A petición del empleado, el doctor conduciendo el examen, debe proporcionar al empleado, dentro de un plazo razonable después del examen, un informe idéntico al que envió al empleador o compañía de seguros del empleador. Los empleados tienen derecho a tener su propio médico presente, y participar en cualquier examen médico ordenado por el empleador. Si esto no se permite, o si no se proporciona una copia del reporte médico a los empleados, entonces el examen ordenado por el empleador no será admitido como evidencia relacionada con el reclamo.

Fraude y Abuso

La División de Compensación de Trabajadores y el Departamento de Seguros de Kansas tienen unidades dedicadas la investigación de actos fraudulentos o abusivos y prácticas que ocurren con respecto a la Ley de compensación de trabajadores. Generalmente pueden ser actos o conductas que se consideran fraudulentas o abusivas descritos como situaciones en que los reclamantes, empleadores o empresas fallan o se niegan a seguir las directrices de la ley de compensación de trabajadores. La ley de compensación de trabajadores aplica a lo siguiente:

- personas reclamando beneficios bajo la Ley de Compensación de Trabajadores;
- los empleadores sujetos a los requisitos de la Ley de Compensación de Trabajadores;
- planes de aseguradoras y grupos mancomunados auto-asegurados, proporcionando cobertura para lesiones relacionadas con el trabajo.
- cualquier persona, empresa, negocio o clínica de salud proporcionando tratamiento para lesiones relacionadas con el trabajo;
- abogados y otros representantes de los empleadores, empleados, aseguradores o de otras entidades involucradas en la administración de la Ley de Compensación de Trabajadores.

Si el director o el fiscal adjunto asignado a la División de Compensación de Trabajadores, tiene causa probable para creer que un acto fraudulento o abusivo o práctica que viola la Ley de Compensación de Trabajadores ha ocurrido, una copia de cualquier orden y todos los informes de investigación y cualquier evidencia en la posesión de la División de Compensación de Trabajadores que se relaciona a dicha ley deberá remitirse al fiscal del condado en el que ocurrió el acto.

Cualquier persona que cree que se ha ocurrido una violación a la ley de Compensación de Trabajadores puede notificar a la División de Compensación de Trabajadores inmediatamente y debe enviar la información relativa a la presunta violación a la División. El director deberá evaluar los hechos en torno a la supuesta violación para determinar en qué medida, si los hubiere, cuales violaciones de la Ley de Compensación de Trabajadores existe. Para obtener más información, llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe un correo electrónico a wcfraud@dol.ks.gov.

Cualquier persona que tenga una queja contra una compañía de seguros, o de otra persona/entidad regulada por Departamento de Seguros de Kansas, en relación con la tramitación de un reclamo de compensación de trabajadores, debe comunicarse con la División de lucha contra fraude en el Departamento de Seguros de Kansas. Las quejas pueden hacerse llamando a los teléfonos (800) 432-2484 o (785) 296-3071, por escrito enviando información a la División de lucha contra fraude a 420 SW 9th St., Topeka, KS 66612 o en el internet en www.ksinsurance.org.

Cobertura y Cumplimiento de Normas

La sección de Cumplimiento supervisa y asiste a los empleadores para asegurar que cumplan con dos requisitos bajo la Ley de Compensación de trabajadores:

1. para proteger los beneficios de compensación de trabajadores para empleados y
2. para presentar informes por escrito de supuestos accidentes de trabajo.

Falta de asegurar beneficios de compensación de trabajadores o de reportar accidentes puede resultar en penas monetarias contra el empleador. Falta de asegurar beneficios de compensación a los trabajadores también puede resultar en la clausura del negocio.

De acuerdo con la ley K.S.A. 44-557, *es...la responsabilidad de cada empleador de hacer o causar que se haga un reporte a el director* de cualquier accidente, relamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones.*

Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en: http://www.dol.ks.gov/WorkComp/edinews.aspx.

Cuando el director tiene motivos para creer que un empleador ha incurrido en el conocimiento y falta intencional de asegurar el pago de compensación de Trabajadores a sus empleados, el director deberá emitir y entregar a tal empleador una declaración de los cargos y deberá conducir una audiencia de conformidad con la Ley de Procedimientos Administrativos del estado de Kansas. El empleador puede ser responsable ante el Estado por una pena civil en una cantidad igual a dos veces la prima anual o 25,000 dólares, cualquier cantidad que sea mayor.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A. R. 51-9-17.

El director deberá ordenar a los empleadores de entrar bajo la ley de Compensación de Trabajadores mediante:

1. asegurar y mantener asegurado el pago de dicha compensación con una compañía de seguros autorizada para tramitar las actividades de seguro de compensación de trabajadores en el estado de Kansas;
2. mostrando al director que el empleador porta ese riesgo propio y que es conocido por estar auto-asegurado y mediante proveer prueba al director de la capacidad financiera del empleador de pagar dicha compensación por sí mismo; o
3. manteniendo una membrecía en un grupo financiero de fondo común que sea cualificado. El costo para proveer dicho seguro o riesgo deberá ser pagado por el empleador y no el empleado.

Para mas información llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe su correo electrónico a: wccompliance@dol.ks.gov o visite el sitio en internet www.dol.ks.gov.

Compruebe Cobertura

Usted puede comprobar si una empresa tiene cobertura de compensación de trabajadores en el internet. El sitio proporciona acceso al público a porciones de la información reportada por compañías aseguradoras privadas de compensación de trabajadores para uso del Departamento Laboral de Kansas (KDOL). La exactitud de los datos de cualquier tercer partido no puede ser garantizado por la agencia y KDOL no es responsable de la información de cobertura disponible a través de este enlace.

Para obtener ayuda adicional para verificar la cobertura de compensación de trabajadores en Kansas, llamar a Cobertura y cumplimiento de normas de la División de Compensación de Trabajadores al (785) 296-4000.

Servicios de Salud y Seguridad

La prevención de accidentes y seguridad en el lugar de trabajo es un elemento clave de la ley. Este requisito fue diseñado para reducir reclamos/pérdidas, lo que mantendría bajas las primas para los empleadores. Debido a que las tarifas se basan en las pérdidas, la prevención de accidentes de los empleados, a través de medidas elevadas de seguridad, es una de las mejores maneras en que los empleadores pueden ayudar a mantener bajas las tasas de interés.

De acuerdo con la ley, las compañías de seguros y planes de grupos financieros deben proporcionar programas de prevención de accidente cuando sea solicitado por sus asegurados. Aviso de tales programas de prevención de accidentes debe aparecer en la portada de todas las pólizas emitidas después de julio de 1993.

Programas Ofrecidos por el Departamento Laboral de Kansas

Consulta: ofrece asistencia a los empleadores del sector privado en las evaluaciones del programa de salud y seguridad. Los consultores ofrecen asesoría en el reconocimiento, evaluación y control de riesgos laborales. Asistencia con la iniciación y el desarrollo del programa está disponible. Entrenamiento, formal e informal, es realizado en todas las áreas de salud y seguridad. Todos los servicios son sin costo al cliente.

Cumplimiento del Sector Público: supervisa al sector público – ciudades, condados, agencias estatales y distritos escolares – mediante la realización de auditorías de cumplimiento bajo el artículo K.S.A. 44-636 o K.S.A. 44-575(f). Se identifican los riesgos laborales y se evalúan los elementos del programa. Los riesgos deben ser disminuidos dentro de 60 días. También se realizan investigaciones de quejas de empleados, accidentes leves y fatalidades.

Prevención de Accidentes: evalúa las compañías de seguros y planes de auto-seguro de grupo financiero para garantizar que están ofreciendo y proporcionando servicios de seguridad y salud sin costo para sus asegurados, como es requerido por la ley. La calidad y cantidad de estos servicios son evaluadas por consultores capacitados mediante revisar directamente los registros de la compañía de seguros y ponerse en contacto con aquellos que han solicitado y han recibido los servicios.

Asistencia en Prevención de Accidentes está disponible mediante correspondencia electrónica AccidentPrevention@dol.ks.gov. También puede encontrar información en linea en: www.dol.ks.gov/Safety/accident.aspx.

Conferencia de Salud y Seguridad: la Conferencia anual de Salud y Seguridad de Kansas reúne a los representantes del sector industrial, académico, proveedor y del Gobierno. La Conferencia se lleva a cabo sin la ayuda de otros y trata de abordar las cuestiones relevantes de seguridad en una variedad de talleres y presentaciones.

Asistencia para salud y seguridad en el lugar de empleo está disponible llamando al (785) 296-4386 o envío de correo electrónico a indsafetyhealth@dol.ks.gov. Usted también puede encontrar información en el internet bajo Seguridad Laboral visitando www.dol.ks.gov.

Servicios de la Sección Ombudsman

La División de Compensación de trabajadores de Kansas estableció una Sección de Asesoramiento al Reclamante en el año de 1978. En 1993 la Legislatura siguió una tendencia nacional y, por ley, crearon el programa Ombudsman. La legislación de reforma de la compensación de los trabajadores en 1993 se ordenó una definición más amplia para la Sección de Consejeros para Reclamantes, facilitando el llevar un papel más activo para ayudar a todos los participantes a entender sus derechos y sus responsabilidades bajo la ley de Compensación para Trabajadores.

La División emplea personal de tiempo completo que se especializan en ayudar a los trabajadores lesionados, los empleadores y profesionales en seguros con información de reclamos y problemas derivados de accidentes de trabajo y enfermedades. El ombudsman actúa de manera imparcial y está disponible para proporcionar a los participantes información acerca de asuntos actualizados dentro del sistema de compensación de trabajadores. Por ejemplo, el ombudsman tiene información actualizada sobre cambios legislativos o modificaciones debido a decisiones tomadas por la Junta de compensación de trabajadores o del sistema legal. La sección de ombudsman también puede ayudar con temas específicos o reclamos actuales de compensación de trabajadores.

Ayudando a los trabajadores lesionados con:

- Proporcionando información general
- Obteniendo tratamiento médico
- Beneficios no pagados o no pagados oportunamente
- Beneficios médicos no pagados
- Cálculos de beneficios
- Notificación oportuna del empleador
- Procedimientos para la solicitud de una audiencia
- Obtención de beneficios de los sobrevivientes
- Resolución informal de disputas
- Asistencia de mediación
- Interpretación para los trabajadores de habla hispana

Ayudar a los empleadores/compañías de seguros:

- Proporcionando información general
- Exhibir el aviso de Compensación de Trabajadores (K-WC 40-A)
- Proporcionando información requerida a los trabajadores lesionados (K-WC 27-A/ K-WC 270-A)
- Presentación oportuna de los reportes de accidentes
- Pago oportuno y adecuado de los servicios médicos
- Información de elecciones
- Asistencia con requisitos del beneficio por fallecimiento
- Resolución de disputa informal
- Asistencia con los trabajadores de habla hispana
- Capacitación del personal de empleador en cuestiones de compensación de trabajadores
- Visitas de asistencia práctica a los sitios de trabajo

Asistencia de un Ombudsman está disponible ya sea en persona o llamando al (785) 296-4000 o al (800) 332-0353. Usted también puede enviar un correo electrónico a wc@dol.ks.gov. Además, los formularios están disponibles para su descarga en www.dol.ks.gov.

Unidad de servicios al empleador

Para asistencia técnica y presentaciones y capacitación para empleadores, llame al (785) 296-4000 o (800) 332-0353, o escriba al correo electrónico wcemployerservices@dol.ks.gov.

Mediación

La mediación fue legislativamente creada en 1996 (K.S.A. 44- 5,117) y puede ser utilizada en cualquier momento durante el proceso de compensación de trabajadores. El estatuto fue enmendado en 1998 para permitir la mediación por video conferencias. La mediación no es obligatoria o un requisito previo para una audiencia y puede ser utilizado en cualquier tiempo durante el proceso de compensación del trabajador. Los asuntos que se pueden mediar no se limitan a cuestiones de tratamiento médico o beneficios de incapacidad total temporal.

¿Qué es la Mediación?

La mediación es un medio de resolver los conflictos en un informal y no contencioso ambiente. El las partes en una controversia utilizan un tercer partido neutral para facilitar la discusión. El mediador no tiene ninguna autoridad haciendo decisiones o interés en el resultado del conflicto. El trabajo del mediador es ayudar a las partes involucradas para identificar las cuestiones en disputa y el establecimiento de objetivos comunes. La clave de la mediación es que permite las partes involucradas a trabajar a través de su disputa y crear sus propios acuerdos.

¿Quiénes son los Mediadores?

Los mediadores son empleados de la División de Compensación de Trabajadores que han recibido especial capacitación en el proceso de mediación. Los mediadores utilizados por la División de compensación para trabajadores cumplen o superan los requisitos establecidos por K.S.A. 5-501 y enmiendas al mismo y cualquier regla pertinente de la Corte Suprema de Kansas en conformidad con el artículo K.S.A. 5-510 y enmiendas. Los mediadores reciben capacitación en técnicas de resolución de conflictos, neutralidad, preparación de acuerdos, ética, desempeño como mediador, habilidades de comunicación, evaluación de casos y las leyes que rigen la mediación.

Representación y Asistencia

Cualquiera de los participantes podrá estar representado por un abogado en esta conferencia de mediación o podrá solicitar asistencia de la Sección Ombudsman/Consejeros de Reclamos. La ausencia de un abogado durante el proceso no significa que representación legal no puede obtenerse posteriormente si la disputa no se resuelve en este contexto informal.

Para obtener información adicional o para programar una conferencia de mediación, llame al (785) 296-4000 o (800) 332-0353. Escribir a la Sección de Mediación, Departamento Laboral de Kansas, División de Compensación de Trabajadores, 401 SW Topeka Boulevard, Topeka, KS 66603-3182. Puede enviar correo electrónico a wcmediation@dol.ks.gov.

Servicios Médicos

La función principal de la sección de Servicios Médicos es la administración de la programación de honorarios médicos. El programa de honorarios es actualizado y revisado anualmente para promover la contención del costo de salud, y todavía asegurar la disponibilidad de tratamiento necesario y cuidado para los empleados lesionados.

La sección de Servicios Médicos está disponible para actuar como un enlace entre los proveedores de atención médica, empleadores, empleados, aseguradoras, grupos financieros con fondo común o empresas auto-aseguradas. Además, la sección conduce audiencias informales para ayudar en la resolución de reclamos médicos en disputa y pagos relacionados que envuelven a proveedores de atención médica.

Para obtener ayuda para resolver los problemas relacionados con interpretación de programación de tarifa, disputas de pago, etc., contacte la sección de servicios médicos al (785) 296-4000 o fax (785) 296-0025.

Rehabilitación Vocacional

Rehabilitación profesional podrá facilitarse a opción del empleador o de la aseguradora del empleador. La experiencia general ha demostrado que cuanto mayor sea el lapso de tiempo que el empleado esté fuera del trabajo en recuperación de una lesión, mayor será la probabilidad de que un empleado necesitará rehabilitación vocacional para reanudar trabajo adecuado a una remuneración comparable.

Si el empleador o la compañía de seguros no eligen proporcionar rehabilitación profesional, el empleado puede pedir al administrador de rehabilitación una referencia con un proveedor de dichos servicios a expensas del empleado. El empleado también puede solicitar una referencia a la División de Servicios de Rehabilitación en el Departamento por Niños y Familias.

Para obtener ayuda con la rehabilitación profesional, póngase en contacto con la oficina del administrador de rehabilitación en la División de Compensación de Trabajadores (800) 332-0353, (785) 296-4000 o envíe un correo electrónico a wcrehab@dol.ks.gov.

Departamento Laboral de Kansas
División de Compensación de Trabajadores

Departamento de Seguros de Kansas

workers' compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE

NEW YORK, NEW YORK 10022

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

HOSPITAL COURIERS HOLDINGS, LLC

129 NEW CAMELIA BLVD.

COVINGTON LA 70433

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised 5/2003

LOUISIANA WORKS™
DEPARTMENT OF LABOR

www.LAWORKS.net

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene rezones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparace en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE

NEW YORK, NEW YORK 10022

La notificación deberá ser dada ya sea lleváandola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

Empleador

HOSPITAL COURIERS HOLDINGS, LLC

129 NEW CAMELIA BLVD.

COVINGTON LA 70433

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net

Workers' compensation

If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.

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

  The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

Workers' compensation pays for

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

What the insurer must do

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

  If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 1-888-372-8366 to report worker's compensation fraud.

Insurer name and contact information

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE
NEW YORK, NEW YORK 10022

Phone number 646-227-6563

DEPARTMENT OF LABOR AND INDUSTRY

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

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

August 2017

Compensación laboral

Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podria perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada,(CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.

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

  La compañía aseguradora no puede obtener otros expedientes médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación por escrito de su médico sobre cualquier autorización para ausentarse del trabajo. La nota debe ser lo más específica posible.

compensación laboral paga por lo siguiente

- Atención médica para su lesión ocurrida en el trabajo, siempre que sea razonable y necesaria.
- Beneficios por salario perdido para cubrir parte de los ingresos no recibidos.
- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
- Servicios de rehabilitación vocacional si usted no puede regresar al trabajo o a su empleador previo al accidente debido a su lesión en el trabajo.
- Beneficios para su cónyuge o dependientes si usted fallece como consecuencia de una lesión laboral.

Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a su reclamo por lesión.
- **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:**
  La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
- **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:**
  La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.

  Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con el teléfono gratuito para Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al 1-800-342-5354.**

Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Llame al 1-888-FRAUD MN (1-888-372-8366) para reportar fraude de compensación laboral.

Nombre e información de contacto de la compañía aseguradora

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE
NEW YORK, NEW YORK 10022

Número de teléfono 646-227-6563

DEPARTAMENTO DE TRABAJO E INDUSTRIA

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self-Insured

Name STARR INDEMNITY & LIABILITY CO

Address 399 PARK AVENUE
NEW YORK, NEW YORK 10022

Phone 646-227-6563

EMPLOYEE INFORMATION

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

l. Notify your employer immediately (written notice must be provided within 30 days of the injury/or 30 days when reasonably aware of the work-relatedness of occupational illness or disease) by contacting

_____ , _____ .
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

2. **Seek medical attention (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need.

Visit www.labor.mo.gov/DWC or call 800-775-COMP.

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately.** The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:
- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:
If an employee dies on the job, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or admitted self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud - knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class D felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Fraud - knowingly misrepresenting an employee's job classification to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class D felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class C felony.

Insurer Fraud - knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class D felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Noncompliance - knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class D felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

INFORMACIÓN DEL EMPLEADO

La División de Compensación a los Trabajadores de Missouri (DWC) administra programas para los trabajadores que se han lesionado en el trabajo o han estado expuestos a una enfermedad ocupacional que surge en el transcurso de su empleo. Los Jueces administrativos de la División tienen la autoridad para aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada con el derecho de un empleado lesionado a los beneficios.

Compañía de seguros, Administrador independiente, Compañía de servicios o Persona designada si tiene seguro propio

Nombre STARR INDEMNITY & LIABILITY CO

Dirección 399 PARK AVENUE
NEW YORK, NEW YORK 10022

Teléfono 646-227-6563

Pasos a tomar si se lesiona en el trabajo

1. Notifique inmediatamente a su empleador (debe presentarse un aviso por escrito dentro de los 30 días de ocurrir una lesión o 30 días cuando se sabe de manera razonable de la relación de la enfermedad ocupacional con el trabajo) comunicándose con

   _____, _____.
   representante del empleador *número de teléfono*

   No hacerlo puede poner en peligro la capacidad de recibir sus beneficios
2. **Busque atención médica (su empleador/asegurador es responsable de proporcionarle el tratamiento médico y pagar los honorarios y gastos médicos, a menos que usted opte por visitar a otro médico, por su propia cuenta, sin la aprobación de su empleador/asegurador).**
3. Obtenga más información sobre los beneficios disponibles bajo el Programa de Compensación a los Trabajadores o sobre los pasos que debe seguir para obtener los beneficios que necesita.

Visite www.labor.mo.gov/DWC o llame al 800-775-COMP.

Beneficios para los empleados lesionados

Cuidado médico:
El empleador o asegurador tiene que proporcionar tratamiento y cuidado médico para curar y aliviar los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. No hay deducibles y todos los costos los paga el empleador o su compañía de seguro de compensación a los trabajadores. Si usted recibe una factura, **comuníquese inmediatamente con su empleador o con la compañía de seguros.** El empleador o asegurador tiene derecho de escoger el proveedor de cuidado de salud o médico tratante. Usted puede seleccionar a otro proveedor de cuidado de salud o médico tratante, pero si lo hace, puede ser por su propia cuenta.

Pago por salarios perdidos:
- Si un médico dice que usted no puede trabajar debido a sus lesiones o a la recuperación de una cirugía, puede tener derecho a beneficios por **incapacidad total temporal** (TTD). Si un médico dice que usted puede realizar labores livianas o modificadas de trabajo y su empleador le ofrece dicho trabajo, puede que no sea elegible para beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede volver a trabajar o cuando su tratamiento haya terminado porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a trabajar en labores ligeras o modificadas por menos del salario completo, puede que tenga derecho a recibir beneficios por **incapacidad parcial temporal.**

Beneficios por incapacidad permanente:
Si la lesión o enfermedad da lugar a una incapacidad permanente, usted puede tener derecho a recibir beneficios ya sea por incapacidad parcial permanente o por incapacidad total permanente.

Beneficios de sobreviviente:
Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficios por muerte semanales pagados al 66 2/3% del salario promedio semanal del empleado fallecido, junto con gastos funerarios de hasta $5,000 por parte del empleador/asegurador. Para información adicional relacionada con los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para hijos sobrevivientes, visite www.labor.mo.gov/DWC.

Ley de Compensación a los Trabajadores

Papel a desempeñar y responsabilidades de empleadores y empleados

INFORMACIÓN DEL EMPLEADOR

Salvo algunas excepciones, todos los empleadores que tengan cinco o más empleados y los empleadores de la industria de la construcción que tengan uno o más empleados tienen que garantizar la obligación legal de la compensación a sus trabajadores, ya sea comprando una póliza u obteniendo la autoridad de tener seguro propio. El seguro de compensación a los trabajadores proporciona beneficios a los trabajadores que se lesionan en el trabajo. Los empleadores también tienen que exhibir este aviso en el lugar de trabajo de manera que los empleados lo vean. Este póster es obligatorio conforme a la sección 287.127, Estatutos Revisados de Missouri, y está disponible para empleadores y aseguradores sin costo alguno a través de la División llamando al 800-775-Comp.

Pasos a tomar si ocurre una lesión

1. Asegúrese de que se le den los primeros auxilios y lleven al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Informe sobre la lesión a la compañía de seguros o Administrador externo (TPA) dentro de un plazo de cinco días a partir de la fecha de la lesión o de la fecha en que el empleado informó al empleador sobre la lesión, lo que ocurra más tarde. El asegurador, TPA o el asegurador por cuenta propia reconocido es responsable de presentar un Primer Informe de Lesión ante la División de Compensación a los Trabajadores **dentro de los 30 días** de haber tenido conocimiento de la lesión.
3. Pague las facturas médicas relacionadas con la lesión en el trabajo para curar y aliviar al empleado de los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. El empleador tiene derecho de escoger el proveedor de cuidado de la salud o médico tratante. (El empleado puede seleccionar a otro proveedor de cuidado de la salud o médico tratante, pero si lo hace, puede ser por su propia cuenta).
4. Para más información de seguro y responsabilidad relacionados con el Programa de Compensación a los Trabajadores, visite www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad de los trabajadores

Desarrollar e implementar un programa completo de salud y seguridad puede reducir las lesiones ocupacionales y ayudar a reducir los gastos de compensación a los trabajadores. Las compañías aseguradoras en el estado de Missouri tienen que proporcionar asistencia en seguridad cuando un empleador asegurado la solicita. El Departamento del Trabajo de Missouri evalúa estos servicios y brinda ayuda adicional a través de su Programa de Seguridad de los Trabajadores de Missouri.

Visite www.labor.mo.gov/MWSP o llame al 573-751-4231 para obtener más información sobre estos programas o un registro de consultores independientes que están certificados en el estado de Missouri para proporcionar asistencia en seguridad.

Fraude/Falta de cumplimiento

Fraude del empleado - presentar a sabiendas una reclamación de beneficios por compensación a los trabajadores a los cuales el empleado sabe que no tiene derecho o presentar a sabiendas múltiples reclamaciones por el mismo incidente con intención de defraudar es un delito grave de clase D, que se castiga con una multa de $10,000 o del doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

Fraude del empleador - alterar a sabiendas la clasificación de empleo de un empleado con el objetivo de obtener seguro a una tarifa menor de la que corresponde es un delito menor de clase A. Una infracción posterior es un delito grave de clase D. Un empleador que hace una declaración falsa o fraudulenta a sabiendas relacionada con el derecho de un empleado a recibir beneficios con el objetivo de disuadir al trabajador de presentar una reclamación legítima, o que hace una declaración o descripción fundamental falsa o fraudulenta a sabiendas para negar beneficios a un trabajador es culpable de un delito menor de clase A que se castiga con una multa de hasta $10,000. Una infracción subsiguiente es un delito grave de clase C.

Fraude del asegurador - negarse, a sabiendas y deliberadamente, a cumplir con las obligaciones de la compensación a los trabajadores a la cual la compañía de seguros o asegurador por cuenta propia sabe que un empleado tiene derecho es un delito grave de clase D que se castiga con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

Falta de cumplimiento del empleador - no garantizar, a sabiendas, la obligación de la compensación a los Trabajadores es un delito menor de clase A que se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una infracción posterior es un delito grave de clase D. Un empleador que intencionalmente no coloca el anuncio de la compensación a los trabajadores en el lugar de trabajo es culpable de un delito menor de clase A que se castiga con una multa de $50 a $1,000, o prisión o ambas.

SAFETY

AVOID THE WORST

BE PART OF THE
SAFETY TEAM

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: HOSPITAL COURIERS HOLDINGS, LLC has workers' compensation insurance coverage from STARR INDEMNITY & LIABILITY CO. In the event of work-related injury or occupational disease. This coverage is effective from 09/23/2019. Any injuries or occupational diseases which occur on or after that date will be handled by STARR INDEMNITY & LIABILITY CO. 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.

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NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: HOSPITAL COURIERS HOLDINGS, LLC has workers' compensation insurance coverage from STARR INDEMNITY & LIABILITY CO. In the event of work-related injury or occupational disease. This coverage is effective from 09/23/2019. Any injuries or occupational diseases which occur on or after that date will be handled by STARR INDEMNITY & LIABILITY CO. 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

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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).

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4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

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WORKERS' COMPENSATION NOTICE

Employer: HOSPITAL COURIERS, LLC
has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: STARR INDEMNITY & LIABILITY CO

Policy Number: 100 0003868

Address for the above insurance company: 399 PARK AVENUE
NEW YORK, NEW YORK 10022

Telephone number: 646-227-6563

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers'compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH - LABOR COMMISSION
160 EAST 300 SOUTH – 3rd FLOOR, PO BOX 146610
SALT LAKE CITY, UT 84114-6610
Phone: (801) 530-6800 • Toll Free: (800)530-5090 • Email: IACCD@utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Revised May 2017

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compensation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.

2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.

3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.

4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.

2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.

3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

NOTIFICATION OF AVAILABLE LOSS CONTROL CONSULTATION SERVICES
CALIFORNIA WORKERS COMPENSATION

Starr maintains and provides Loss Control Services as required by California law. These services may be provided to our insured workers compensation policyholder places of employment. Starr is committed to helping our workers compensation policyholders provide for safe and healthy workplaces for their California employees through the provision of loss control services appropriate to the individual business.

Available services that may be provided if requested include:

- A workplace survey to identify safety and health hazards and their control.
- A review of workers compensation injury records to identify accident trends and their causes.
- Assistance in the development of your loss control management plan to minimize workplace injuries.

This includes a review of your 8 CCR, Sec. 3203 employer's Injury and Illness Prevention Program (IIPP). As appropriate, written findings and recommendations will be made that address uncontrolled hazards and program deficiencies including your employer's Injury and Illness Prevention Program. The above services are available at no additional charge to Starr workers compensation policyholders for their covered California employees.

To request such services, please contact **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th Floor
New York, NY 10022

IMPORTANT: When leaving a message please provide your name, phone number, company name and the nature of your request.

Workers' compensation insurance policyholders may direct questions or complaints about the insurers loss control consultation services by contacting: State of California, Department of Industrial Relations, Loss Control Services Coordinator, The Commission on Health, Safety & Workers' Compensation, 455 Golden Gate Avenue, 10th Floor, San Francisco, CA 94102, phone (415) 703-4220.

FLORIDA NOTICE OF RISK MANAGEMENT PROGRAM AVAILABILITY

Florida regulations require us to develop and make available for use by our clients a Risk Management Guide. We are pleased to present to you Starr's Risk Management Guide, which includes measures, services and plans we have developed. The scope of your Risk Management Program should include the following:

1. Safety measures, including, as applicable, the following areas:

    a. Pollution and environmental hazards;
    b. Disease hazards;
    c. Accidental occurrences;
    d. Fire hazards and fire prevention and detection;
    e. Liability for acts from the course of business;
    f. Slip and fall hazards;
    g. Products injury; and
    h. Hazards unique to a particular class or category of policyholders.

2. Training to policyholders in safety management techniques.

3. Safety management counseling services.

Our guide and services are available upon request to assist in your risk management efforts. If you would like to further discuss these services, please contact us at **1-855-656-6365** or at LC.Staterequest@starrcompanies.com. You may also write to us at the following address:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th floor
New York, NY 10022

If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, policy number and a brief description of the loss control services being requested.

FLORIDA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE

Florida law requires that we provide a notice outlining the availability of a state-authorized $2,500 deductible plan for medical and indemnity expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY.

There is no premium credit associated with this option, but any amounts paid by the employer shall not apply to the experience rating of such employer.

IMPORTANT NOTICE

KANSAS WORKERS' COMPENSATION POLICYHOLDERS

In compliance with KSA 44-5104, entitled Kansas Workers Compensation Law, our accident prevention services, which meet the standards of that law, are available to you upon request.

To request such services, please contact **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th Floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

MINNESOTA SAFETY PROGRAM NOTICE

In accordance with Minnesota Statute §79.085, we are advising you of your right under this section to obtain certain safety and occupational health loss consultation services.

Upon your request, we will provide services to you including surveys to identify health and safety problems, review of employer injury records with appropriate personnel, and development of plans to improve employer occupational health and safety loss records.

For more information regarding these services, please contact **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief decription of the loss control services being requested.

NOTIFICATION OF AVAILABLE LOSS CONTROL SERVICES
MISSOURI WORKERS' COMPENSATION POLICYHOLDERS

You are hereby notified that loss control services are available, upon request, to workers' compensation policyholders with employees working in Missouri. The services are intended to provide employers with appropriate resources to address workplace safety and health issues and reduce insured losses through a safety engineering and management program. This notice is provided pursuant to the requirements of Missouri Law. If you would like more information please contact us at **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th Floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

The Missouri Division of Workers' Compensation offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goal is to help employers control workers' compensation costs. The Division also certifies Missouri insurance carriers' safety engineering and management programs that are available to insured's upon request.

Employers may contact MWSP at 1(800)775-COMP or 573-526-3504, email mowsp@dolir.mo.gov for more information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

IMPORTANT NOTICE
OREGON WORKERS COMPENSATION POLICYHOLDERS
AVAILABLE LOSS PREVENTION SERVICES

Starr is required by section 437-001-1025 of the Oregon Administrative Rules of the Oregon Occupational Safety and Health Division to notify our workers compensation policyholders with Oregon employees of available loss prevention services. The State of Oregon under the Oregon Safe Employment Act (ORS 654.001 § 654.295 and 654.991) makes employers responsible to provide a safe and healthful workplace. Our Loss Control Department can provide the required and appropriate services to assist Oregon policyholders meet their safety and health responsibilities.

The following services are available upon request for your Oregon operations:

- Evaluation of your loss prevention needs.
- Assistance in evaluating injury and illness records to determine the loss experience and trends.
- An explanation of the Oregon Safe Employment Act and rules that apply to your particular place of employment.
- Provision of partial or complete on-site health and safety surveys, which identify all reasonably discoverable occupational safety and health hazards within the scope of the survey scheduled.
- Assistance with industrial hygiene and safety evaluations to detect physical and chemical hazards of the workplace, and implementation of engineering or administrative controls.
- Assistance with evaluating, obtaining, and maintaining personal protective equipment.
- Evaluation of work practices, workplace design, and assistance with job site modifications related to injury and illness prevention.
- Assistance in evaluation and improving your safety management practices.
- Assistance in identifying health and safety training needs and available resources.
- The provision of follow up services as appropriate.

If you would like to further discuss these services, please contact us at **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th Floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

As the insurance responsible person for your company, we ask that you forward this notice to your main Oregon office and each fixed place of employment in Oregon. Should we fail to respond to your request for loss prevention services or otherwise fail to provide services as offered or required, you may file a complaint with the OR- OSHA Division.

SOUTH DAKOTA POLICYHOLDER NOTICE

NOTICE OF ACCIDENT PREVENTION CONSULTING SERVICES

Starr is required by law to provide its policyholders with certain accident prevention services as required by South Dakota Insurance Code: § 58-21-20 at no additional cost. If you would like more information call: 1-855-656-6365.

If you would like to further discuss these services, please contact us at **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief decription of the loss control services being requested.

IMPORTANT NOTICE TO TEXAS POLICYHOLDERS

ACCIDENT PREVENTION SERVICES

Pursuant to Texas Labor Code §411.066, Starr is required to notify its policyholders that accident prevention services are available from Starr at no additional charge. These services may include:

- Surveys
- Recommendations
- Training Programs
- Consultations
- Analyses of Accident Causes
- Industrial Hygiene
- Industrial Health Services

Starr 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, please contact Starr at **1-855-656-6365** and LC.Staterequest@starrcompanies.com for accident prevention services or **1-855-827-5362** and Claims.StateRTW@starrcompanies.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 1-512-804-5000. If Starr 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;

PRIVACY POLICY AND PRACTICES

THIS NOTICE IS BEING SENT TO THE WORKERS' COMPENSATION PLAN PARTICIPANT (EMPLOYER). IT DESCRIBES THE POLICY OF STARR COMPANIES FOR HANDLING CERTAIN PERSONAL INFORMATION OF ITS INDIVIDUAL CUSTOMERS. THIS NOTICE IS PROVIDED TO THE EMPLOYER TO SATISFY STARR COMPANIES' NOTICE OBLIGATIONS UNDER STATE LAW.

Starr Companies collects certain personal information about you, which is described below in The Personal Information We Collect section. At Starr Companies, we respect the privacy of our customers. Our personal information handling practices are regulated by law, and this Privacy Policy describes those practices.

Starr Companies Privacy Policy

The Personal Information We Collect

Starr Companies collects personal information about you and the members of your household to conduct business operations, provide customer service, offer new products and satisfy legal and regulatory requirements.

We may collect the following categories of information about you from different sources. Examples include:**:**

- Information from you directly or through an agent, broker, your employer or other third parties such as insurance companies, government agencies, credit reporting agencies, courts or public records, including information from applications, worksheets, questionnaires, claim forms or other documents (such as name, address, telephone number and social security number)
- Information from other non-Starr Companies sources (such as prior loss information)
- Information from an employer, benefit plan sponsor, benefit plan administrator or master policyholder for any individual or group insurance product that you may have (such as name, address and social security number)

The Personal Information We Share

Starr Companies may disclose the personal information we collect to service, process, or administer business operations such as underwriting and claims, and for other purposes such as the marketing of products or services, regulatory compliance, the detection or prevention of fraud, or as otherwise required or allowed by law. These disclosures may be made without prior authorization from you, as permitted by law.

We may disclose such information about you to our affiliated companies and/or other third parties such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies;
- Reinsurance companies;
- Researchers;
- Business partners;
- Regulators;
- Law enforcement;
- Legal proceedings; and
- Public welfare.

When we use the term "personal information" we mean information that identifies you as an individual such as your name and social security number, your health information, as well as your financial and other information about you that is nonpublic.

You have a right to access and correct the personal information we collect, maintain and disclose about you.

Confidentiality and Security of Personal Information

Access to personal information is allowed for business purposes only. The people who have access to personal information, including employees of Starr Companies and its affiliates, and non-employees performing business functions for Starr Companies, are under obligations to safeguard such information. Starr Companies maintains physical, electronic, and procedural safeguards to guard your personal information.

Changes in Privacy Policy

Starr Companies may choose to modify this policy at any time. We will notify customers of any modifications at least annually.

How to Contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include the following information: your name, address, policy number and daytime phone number.

Starr Companies Privacy Officer
399 Park Avenue
New York, New York 10022
(646) 227-6400

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

IMPORTANT NOTICE TO POLICYHOLDER
FLORIDA

To present inquiries about coverage and/or to obtain assistance in resolving any complaints:

You may call Starr's toll-free telephone number at:

1-866-519-2522

You may also write the company at:

Starr Indemnity & Liability Company
Attn: Legal Department
399 Park Avenue, 8th Floor
New York, NY 10022

You may contact the Florida Office of Insurance Regulation at:

200 East Gaines Street
Tallahassee, FL 32399
Web Address: www.floir.com
Phone: 877-693-5236 (In-State)
850-413-3089 (Out-of State)

Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

Workers Compensation Policy Jacket

Named Insured: **HOSPITAL COURIERS, LLC**

Policy Number: **100 0003868**

Effective Date: **09/23/2019 at 12:01 A.M.**

This Policy is a legal contract between the Named Insured and Starr, a Stock Company, (herein referenced as "the Company"). The Company agrees to provide insurance to the Named Insured, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Named Insured on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state where it was delivered.

IN WITNESS WHEREOF, we have cause this Policy to be signed and countersigned where required by law on the Declarations by our duly Authorized representative.

President &CEO

General Counsel

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street**,** Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

CERTIFICATE OF INDUSTRIAL INSURANCE

INSURED: HOSPITAL COURIERS, LLC

IN ACCORDANCE WITH THE PROVISIONS OF THE NRS 616B.026 THIS *CERTIFICATE* IS PROVIDED FOR THE PURPOSE OF DOCUMENTING THAT THE EMPLOYER NAMED ABOVE HAS OBTAINED COVERAGE FOR ITS STATUTORY OBLIGATIONS UNDER NEVADA WORKERS COMPENSATION STATUTES FROM:

Starr Indemnity & Liability Co

POLICY NUMBER: 100 0003868

EFFECTIVE DATE OF POLICY: 09/23/2019 MO/DA/YR **EXPIRATION DATE:** 09/23/2020 MO/DA/YR

THIS *CERTIFICATE* CONFERS NO RIGHTS UPON THE POLICYHOLDER BEYOND THOSE CONTAINED IN THE POLICY INDICATED ABOVE. THE *CERTIFICATE* CONFIRMS THAT COVERAGE IS PROVIDED AS OF THE EFFECTIVE DATE INDICATED, AND REMAINS IN FORCE AS LONG AS THE POLICYHOLDER IS IN COMPLIANCE WITH ITS DUTIES UNDER THE POLICY. THE *CERTIFICATE* DOES NOT EXTEND COVERAGE IF THE POLICY HAS BEEN CANCELLED OR TERMINATED PRIOR TO THE EXPIRATION DATE, BY EITHER THE INSURED OR THE COMPANY, FOR APPROPRIATE CAUSE, INCLUDING NON-PAYMENT OF PREMIUMS.

****A COPY OF THIS CERTIFICATE MUST BE POSTED AT EACH LOCATION OR JOB SITE****
COPIES CAN BE MADE FOR MULTIPLE LOCATIONS.

HOSPITAL COURIERS, LLC
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ☐ Job applicant
- ☐ Reasonable suspicion
- ☐ Routine fitness for duty
- ☐ Follow-up testing to Employee Assistance Program

Notice of Employer's Drug Testing Policy:

- ☐ Copy to all employees prior to testing
- ☐ Posted on employer's premises
- ☐ Copy to job applicants prior to testing
- ☐ General notice given 60 days prior to testing
- ☐ Show notice of drug testing on vacancy announcements
- ☐ Copies available in personnel office or other suitable locations
- ☐ No notice required because the employer had a drug testing program in place prior to July 1, 1990

Education:

- ☐ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____

B. Phone No.: ( ) _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employer Name	Date	Officer/Owner Signature*
		Title

* Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature	Date	Expiration of Commission

DEDUCTIBLE NOTICE OF ELECTION

Texas law permits an employer to obtain workers compensation insurance with a deductible. The insurance applies only to benefits payable under Texas workers compensation law. When a deductible is elected, the policyholder is required to reimburse the insurance carrier for benefits payable under the law up to the deductible amount and a credit is applied to the policy. Premium credits are determined based on the deductible selected and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

You are not required to choose a deductible. If you do choose one, your insurance company will pay the deductible amount for you, but you must reimburse the insurance company within 30 days after they send you notice that payment is due. If you fail to reimburse the insurance company, they may cancel the policy upon ten days written notice, and any resulting premium may be applied to the deductible amount owed.

If a deductible amount is desired, please indicate below.

☐ Yes, I want a deductible of (select only one):

1. $_____ per accident

2. $_____ per claim

3. $_____ medical only

applied to benefits payable under the Texas Workers Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement _____
(monthly, quarterly or other)

☐ No, I do not want a deductible applied to benefits payable under the Texas Workers Compensation Law.

☐ Yes, I do want a deductible policy, but am unable to obtain one for the following reason:_____

_____

The deductible plans have been explained to me.

_____ _____
Signature and Title Date

_____ _____
Employer Name (print or type) Address

_____ _____ _____
Insurance Company Policy No. Effective Date

STARR INDEMNITY & LIABILITY COMPANY

Dallas, TX 1-866-519-2522

A MEMBER OF STARR COMPANIES

IMPORTANT NOTICE TO POLICYHOLDERS

This Important Notice is not your policy. Please read your policy carefully to determine your rights, duties, and what is and what is not covered. Only the provisions of your policy determine the scope of your insurance protection.

THIS IMPORTANT NOTICE PROVIDES INFORMATION CONCERNING POSSIBLE IMPACT ON YOUR INSURANCE COVERAGE DUE TO COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS.

PLEASE READ THIS NOTICE CAREFULLY.

Various trade or economic sanctions and other laws or regulations prohibit us from providing insurance in certain circumstances. For example, the United States Treasury Department's Office of Foreign Asset Control (OFAC) administers and enforces economic and trade sanctions and places restrictions on transactions with foreign agents, front organizations, terrorists, terrorists organizations, and narcotic traffickers. OFAC acts pursuant to Executive Orders of the President of the United States and specific legislation, to impose controls on transactions and freeze foreign assets under United States jurisdiction. (To learn more about OFAC, please refer to the United States Treasury's web site at www.treas.gov)

To the extent that you or any other insured, or any person or entity claiming the benefits of this insurance has violated any applicable sanction laws, this insurance will not apply.

Steve Blakey

Steve Blakey, President

Nehemiah E. Ginsburg

Nehemiah E. Ginsburg, General Counsel

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us - Starr Indemnity & Liability Company

(1) General questions regarding your policy should be directed to:

Starr Indemnity & Liability Company
One International Place,13th Floor
Boston, MA, 02110

(2) **Dividend Calculation.** If this is a participating policy (a policy on which a dividend may be paid), upon payment or non-payment of a dividend, we shall provide a written explanation to you that sets forth the basis of the dividend calculation. The explanation will be in clear, understandable language and will express the dividend as a dollar amount and as a percentage of the earned premium for the policy year on which the dividend is calculated.

(3) **Claims Information.** Pursuant to Sections 3761 and 3762 of the California Labor Code, you are entitled to receive information in our claim files that affects your premium. Copies of documents will be supplied at your expense during reasonable business hours.

For claims covered under this policy, we will estimate the ultimate cost of unsettled claims for statistical purposes eighteen months after the policy becomes effective and will report those estimates to the Workers' Compensation Insurance Rating Bureau of California (WCIRB) no later than twenty months after the policy becomes effective. The cost of any settled claims will also be reported at that time. At twelve-month intervals thereafter, we will update and report to the WCIRB the estimated cost of any unsettled claims and the actual final cost of any claims settled in the interim. The amounts we report will be used by the WCIRB to compute your experience modification if you are eligible for experience rating.

B. Information Available from the Workers' Compensation Insurance Rating Bureau of California

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan-1995* (USRP) and the *California Workers' Compensation Experience Rating Plan-1995* (ERP).WCIRB contact information is: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service; 888.229.2472 (phone); 415.778.7272 (fax);and customerservice@wcirb.com(email).The regulations contained in the USRP and ERP are available for public viewing through the WCIRB's website at wcirb.com.

(2) **Policyholder Information.** Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

(3) **Experience Rating Form.** Each experience rated risk may receive a single copy of its current Experience Rating Form/Worksheet free of charge by completing a Policyholder Experience Rating Worksheet Request Form on the WCIRB's website at wcirb.com/ratesheet.The Experience Rating Form/Worksheet will include a Loss-Free Rating, which is the experience modification that would have been calculated if $0 (zero) actual losses were incurred during the experience period. This hypothetical rating calculation is provided for informational purposes only.

II. Dispute Process

You may dispute our actions or the actions of the WCIRB pursuant to CIC Sections 11737 and 11753.1.

A. Our Dispute Resolution Process.

If you are aggrieved by our decision adopting a change in a classification assignment that results in increased premium, or by the application of our rating system to your workers' compensation insurance, you may dispute these matters with us. If you are dissatisfied with the outcome of the initial dispute with us, you may send us a written Complaint and Request for Action as outlined below.

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:
Starr Indemnity & Liability Company, One International Place, 13th Floor, Boston, MA, 02110.

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether or not your written request will be reviewed. If we agree to review your request, we must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If we decline to review your request, if you are dissatisfied with the decision upon review, or if we fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below.

B. Disputing the Actions of the WCIRB. If you have been aggrieved by any decision, action, or omission to act of the WCIRB, you may request, in writing, that the WCIRB reconsider its decision, action, or omission to act. You may also request, in writing, that the WCIRB review the manner in which its rating system has been applied in connection with the insurance afforded or offered you. For requests related to classification disputes, the reporting of experience, or coverage issues, your initial request for review must be received by the WCIRB within 12 months after the expiration date of the policy to which the request for review pertains, except if the request involves the application of the Revision of Losses rule. For requests related to your experience modification, your initial request for review must be received by the WCIRB within 6 months after the issuance, or 12 months after the expiration date, of the experience modification to which the request for review pertains, whichever is later, except if the request for review involves the application of the Revision of Losses rule. If the request involves the Revision of Losses rule, the time to state your appeal may be longer. (See Section VI, Rule 7 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB,1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service. Customer Service can be reached at 888.229.2472 (phone), 415.778.7272 (fax) and customerservice@wcirb.com (email).

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether or not your written request will be reviewed. If the WCIRB agrees to review your request, it must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If the WCIRB declines to review your request, if you are dissatisfied with the decision upon review, or if the WCIRB fails to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below. Written Complaints and Requests for Action should be forwarded to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).

C. California Department of Insurance – Appeals to the Insurance Commissioner. After you follow the appropriate dispute resolution process described above, if (1) we or the WCIRB decline to review your request, (2) you are dissatisfied with the decision upon review, or (3) we or the WCIRB fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner pursuant to CIC Sections 11737, 11752.6, 11753.1 and Title 10, California Code of Regulations, Section 2509.40 et seq. You must file your appeal within 30 days after we or the WCIRB send you the notice rejecting review of your Complaint and Request for Action or the decision upon your Complaint and Request for Action. If no written decision regarding your Complaint and Request for Action is sent, your appeal must be filed within 120 days after you sent your Complaint and Request for Action to us or to the WCIRB. The filing address for all appeals to the Insurance Commissioner is:

Administrative Hearing Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco, CA 94105
415.538.4102

You have the right to a hearing before the Insurance Commissioner, and our action, or the action of the WCIRB, may be affirmed, modified or reversed.

III. Resources Available to You in Obtaining Information and Pursuing Disputes

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159(phone), 415.371.5288(fax) and ombudsman@wcirb.com (email).

B. California Department of Insurance - Information and Assistance. Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 800.927.HELP (4357) or insurance.ca.gov. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

This notice does not change the policy to which it is attached.

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws.

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.
2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or might create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.
3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per $100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.
4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.
5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.
6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.
7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

Section 11664 of the California Insurance Code requires us, in most instances, to provide you with a notice of nonrenewal. Except as specified in paragraphs 1 through 6 below, if we elect to nonrenew your policy, we are required to deliver or mail to you a written notice stating the reason or reasons for the nonrenewal of the policy. The notice is required to be sent to you no earlier than 120 days before the end of the policy period and no later than 30 days before the end of the policy period. If we fail to provide you the required notice, we are required to continue the coverage under the policy with no change in the premium rate until 60 days after we provide you with the required notice.

We are not required to provide you with a notice of nonrenewal in any of the following situations:

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.

2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.

5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.

   (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code Section 11750.3(c).

   (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

This notice does not change the policy to which it is attached.

NOTICE REQUIRED BY LAW – CALIFORNIA

Since our offer to renew your coverage reflects a premium rate increase of 25 percent or more in your governing classification, California law (Insurance Code section 11664) requires us to send you a "notice of nonrenewal", even though we do intend to renew your policy. This constitutes the required notice. For purposes of this Notice, premium rate means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

Insured HOSPITAL COURIERS, LLC Date of Notice 09/29/2019

Policy No. 100 0003868 Policy Period 09/23/2019 to 09/23/2020

POLICY HOLDER NOTICE

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent, the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" or "CA Surcharge (CIGA Surcharge)" with an amount will be displayed on your premium notice.

This notice does not change the policy to which it is attached.

POLICYHOLDER NOTICE

PAYROLL RECORD AND AUDIT REQUIREMENTS FOR DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Your policy includes one or more construction or erection classifications. Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

Payroll Record Requirements

The assignment of a high wage classification to any non-salaried employee is contingent on verifying that the employee's hourly wage equals or exceeds the specified wage threshold. The determination of the regular hourly wage must be supported by one of the following sources:

- Original time cards or time book entries for each employee. Original records must include the operations performed, the total hours worked each day and the times the employee started and ended each work period throughout the workday. At job locations where all of the employer's operations cease for a uniform unpaid meal period, recording the start and stop times of the uniform break period is not required.
- A valid collective bargaining agreement that shows the regular hourly wage rate by job classification of a worker. If using a collective bargaining agreement, the records must include an employee roster by job classification that permits the reconciliation of individual employees to the job classifications set forth in the collective bargaining agreement.

The non-salaried employee's regular hourly wage shall be determined by dividing that employee's total remuneration by the hours worked during the pay period, irrespective of whether the employee is paid on an hourly, piecework, production or commission basis.

The payroll earned by any non-salaried employees for whom the records specified above are not maintained and/or made available will be assigned to the low wage classification that describes the operations performed.

The regular hourly wage of salaried employees is determined by dividing the total annual remuneration by 2000 hours. If an employee is salaried for less than 12 months, the regular hourly wage for the salaried period is calculated on a prorated basis.

Audit Requirements

If your policy produces a final premium of $13,000 or more, a physical audit is required at least once a year. If your policy produces a final premium of less than $13,000 and payroll is developed under a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

If you hold a C-39 Roofing Contractor license from the California Contractors State License Board, a physical audit is required on the complete policy period of each policy regardless of the amount of final premium.See California Insurance Code Section 11665(a) for additional requirements regarding the audit of C-39 license holders.

POLICYHOLDER NOTICE

JANUARY 1, 2015 AUDIT REQUIREMENTS FOR POLICIES WITH FINAL PREMIUM OF LESS THAN $13,000 THAT DEVELOP PAYROLL IN HIGH WAGE DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

If your policy effective on or after January 1, 2015 produces a final premium of less than $13,000 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. If your policy produces a final premium of $13,000 or more, a physical audit is required at least once a year.

A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

WORKERS' COMPENSATION DISCLOSURE FORM
IMPORTANT NOTICE TO POLICYHOLDERS

1. Notice Of Change In Rate By Classification

   If you desire information whenever there is a change in your workers' compensation insurance rate by classification, you must request such information from your insurer. This request for information must be in writing.

2. Notice Of Policyholder's Right To Appeal Classification

   Your insurers can charge and collect any additional amount of money not included in the initial premium charged as a result of job misclassification.

   If you have any questions regarding the employee classification assigned to calculate your worker's compensation insurance premium, you need to direct your questions to your insurer or the insurer's authorized representative within thirty (30) days after the anniversary date of the policy or the date of receipt by you of notice of a change in job classification. Within thirty (30) days after receipt of your request for information, your insurer or the insurer's authorized representative must explain to you why a particular employee classification was used.

   If you disagree with your insurer or the insurer's authorized representative on the employee classification assignment, you may appeal to the Workers' Compensation Classification Appeal Board by filing written notice with said board within thirty (30) days after you have exhausted all appeal review procedures provided by the insurer. Your request should be sent to the Secretary of the Colorado Workers' Compensation Classification Appeals Board, c/o National Council on Compensation Insurance, Inc (NCCI), 7220 West Jefferson Avenue, Suite 310, Lakewood , CO 80235. Written instructions for your appearance before the Colorado Workers' Compensation Classification Appeals Board will be furnished by the Secretary of the board. The board will render a decision as to whether a misclassification has occurred.

   A decision by the board is final and not subject to appeal unless you, the insurer or Pinnacol Assurance provides written notice of appeal within thirty (30) days after the board's decision to the office of the Commissioner of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. The Commissioner shall review any decision of the board properly appealed.

3. Notice Of Availability Of Medical Case Management Services

   Because there are different types of case management services available and prescribed by insurers, it is suggested that each insurer include the type of case management services available by the individual insurer.

STARR INDEMNITY & LIABILITY COMPANY

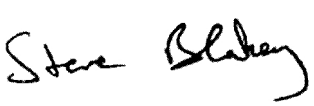
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

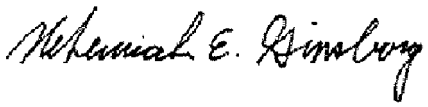
NOTICE TO POLICYHOLDERS

NOTICE: THIS WORKERS' COMPENSATION POLICY CONTAINS A DEDUCTIBLE OPTION, UNDER WHICH YOU THE EMPLOYER, ARE REQUIRED TO REIMBURSE CERTAIN LOSSES.

PLEASE READ THIS POLICY CAREFULLY AND UNDERSTAND ITS CONDITIONS PRIOR TO PURCHASING COVERAGE



Steve Blakey, President



Nehemiah E. Ginsburg, General Counsel

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer as Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:

   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;

   (b) Submit the copy of its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and

   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. § 6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

Policy Number	Policy Period From	To
100 0003868	09/23/2019	09/23/2020
	12:01 A.M. Standard Time at the mailing address of the Insured as stated herein	
Renewal Of	**Transaction**	
	New Business	

1. Named Insured and Mailing Address	**Agent**
HOSPITAL COURIERS, LLC 7200 S ALTON WAY STE A360 CENTENNIAL CO 80112	CLAUDIA MANDATO 444 W 47TH ST STE 900 KANSAS CITY MO 64112

UNEMPLOYMENT ID #	CARRIER #	FEIN #	Risk ID #	Entity of Insured
	11193	383977869	911656256	LIMITED LIABILITY CO

Other Workplaces Not Shown Above: See attached Location Schedule

2. The Policy Period is from 09/23/2019 to 09/23/2020 12:01 a.m. Standard Time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: CA, CO, CT, FL, KS, LA, MN, MO, NV, OR, SD, TX, UT, VA

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:

Bodily Injury by Accident	$	1,000,000	each accident
Bodily Injury by Disease	$	1,000,000	policy limit
Bodily Injury by Disease	$	1,000,000	each employee

C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here: All states except North Dakota, Ohio, Washington, Wyoming, Puerto Rico and states designated in item 3. A. above. .

AL AK AZ AR DE GA HI ID IL IN IA KY LA ME MD MA MI MS MO MT NE NV NH NJ NM NY NC OK PA RI SC TN VT WV WI

D. This policy includes these endorsements and schedules: See attached Endorsement Schedule

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.

Assessments and Taxes **SEE EXTENSION OF INFORMATION PAGE**

Total Estimated Annual Premium	$	1,304,148
Expense Constant	$	260
Premium Discount	$	- 157,549
Deposit Premium	$	1,304,148

Minimum Premium $ 1,000

☐ This is a Three Year Fixed Rate Policy
Premium Adjustment Period: ☒ Annual; ☐ Semiannual; ☐ Quarterly; ☐ Monthly

Countersigned this Day of ,

Issued Date: 09/29/2019

Issuing Office

AUTHORIZED REPRESENTATIVE

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

WC 04 00 01 B

(Ed. 10-14)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

Policy No. 100 0003868

Prior Policy No. _____

INFORMATION PAGE

Insurer ID No(s).

1. Named Insured:
HOSPITAL COURIERS, LLC

Mailing Address:
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112

☐ Individual ☒ LLC
☐ Corporation ☐ LLP
☐ Partnership ☐ Other: _____

Email Address:
FEIN: 383977869
Intra/Interstate Risk ID No. 911656256
Other workplaces not shown above:

2. The policy period is from 09/23/2019 to 09/23/2020 12:01 A.M. standard time at the insured's mailing address.

3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: CA, CO, CT, FL, KS, LA, MN, MO, NV, OR, SD, TX, UT, VA

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident $ 1,000,000 each accident
Bodily Injury by Disease $ 1,000,000 policy limit
Bodily Injury by Disease $ 1,000,000 each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: All states except North Dakota, Ohio, Washington, Wyoming, Puerto Rico and states designated in item 3. A. above..

D. AL AK AZ AR DE
GA HI ID IL IN
IA KY LA ME MD
MA MI MS MO MT
NE NV NH NJ NM
NY NC OK PA RI
SC TN VT WV WI

4. The will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All

This policy includes these endorsements and schedules: See attached Endorsement Schedule

premium for this policy 2.330 Total Estimated Cost $ 1,304,148
information required below is subject to verification and change by audit.
Deposit Premium $ 1,304,148

Assessments and Taxes **SEE EXTENSION OF INFORMATION PAGE**

☐ Experience Modification

Minimum Premium $ 1,000 ☒ Annual; ☐ Semiannual; ☐ Quarterly; ☐ Monthly

Producer Information: CLAUDIA MANDATO

This is a Three Year Fixed Rate Policy ,

Premium Adjustment Period:

Steve Blakey
AUTHORIZED REPRESENTATIVE

Countersigned this Day of

Issued Date: 09/29/2019

Issuing Office

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
CALIFORNIA					
UNIT: 00002 ADDRESS: 3363 PEGASUS DR PERIOD: 09/23/2019 TO 09/23/2020					
7198	PARCEL DELIVERY AND MESSENGER SERVICE COMPANIES - INCLUDING TERMINAL EMPLOYEES AND MECHANICS - NO HANDLING OF BULK MERCHANDISE OR FREIGHT	2,331,888	13.040000	$	304,078.00
8742	SALESPERSONS - OUTSIDE	233,484	0.750000	$	1,751.00
8810	CLERICAL OFFICE EMPLOYEES	105,399	0.530000	$	559.00
	MANUAL PREMIUM			**$**	**306,388.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	306,388	0.028000	$	8,579.00
0930	WAIVER OF SUBROGATION	306,388	1.020000	$	6,128.00
9898	EXPERIENCE MODIFICATION	321,095	2.330000	$	427,056.00
9889	SCHEDULED DEBIT	748,151	1.050000	$	37,408.00
0063	PREMIUM DISCOUNT	785,559	0.109000	$	-85,626.00
CI GAS	CALIFORNIA INSURANCE GUARANTEE ASSOCIATION SURCHARGE	701,509	1.000000	$	0.00
CA AST	CALIFORNIA WORKERS COMPENSATION FRAUD ASSESSMENT FACTOR	701,509	1.002878	$	2,019.00
CA LEC	CA LABOR ENFORCEMENT & COMPLIANCE FUND	701,509	1.003431	$	2,407.00
CA OSH	CA OCCUPATIONAL SAFETY & HEALTH FUND	701,509	1.003765	$	2,641.00
CA SIB	CALIFORNIA SUBSEQUENT INJURIES BENEFIT TRUST FUND ASSESSMENT	701,509	1.002737	$	1,920.00
CA SRG	CALIFORNIA USER FUNDING SURCHARGE	701,509	1.014479	$	10,157.00
CA UEB	CALIFORNIA UNINSURED EMPLOYERS BENEFIT TRUST FUND ASSESSMENT	701,509	1.000831	$	583.00
9740	TERRORISM	2,670,771	0.039000	$	1,042.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	2,670,771	0.020000	$	534.00
	STATE TOTAL			**$**	**721,236.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
COLORADO					
UNIT: 00001 ADDRESS: 7200 S ALTON WAY STE A360 PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	3,956,316	8.330000	$	329,561.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	794,625	0.260000	$	2,066.00
8810	CLERICAL OFFICE EMPLOYEES NOC	753,401	0.130000	$	979.00
	MANUAL PREMIUM			**$**	**332,606.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	332,606	0.011000	$	3,659.00
0930	WAIVER OF SUBROGATION	332,606	1.020000	$	6,652.00
9898	EXPERIENCE MODIFICATION	342,917	0.850000	$	-51,438.00
9889	SCHEDULED DEBIT	291,479	1.050000	$	14,574.00
0063	PREMIUM DISCOUNT	306,053	0.109000	$	-33,360.00
9740	TERRORISM	5,504,342	0.007000	$	385.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	5,504,342	0.015000	$	826.00
	STATE TOTAL			**$**	**273,904.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
CONNECTICUT					
UNIT: 00018 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
8810	CLERICAL OFFICE EMPLOYEES NOC	90,000	0.150000	$	135.00
	MANUAL PREMIUM			**$**	**135.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	135	0.011000	$	1.00
0930	WAIVER OF SUBROGATION	135	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	386	0.850000	$	-58.00
0063	PREMIUM DISCOUNT	328	0.109000	$	-36.00
CM ASM	CT W/C FUND ASSESSMENT	328	1.018000	$	6.00
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	337	1.022500	$	8.00
9740	TERRORISM	90,000	0.040000	$	36.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	90,000	0.010000	$	9.00
	STATE TOTAL			**$**	**351.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
FLORIDA					
UNIT: 00011 ADDRESS: 5361 NORTHWEST 33RD AVENUE PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	834,320	7.780000	$	64,910.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	100,419	0.380000	$	382.00
8810	CLERICAL OFFICE EMPLOYEES NOC	81,120	0.180000	$	146.00
	MANUAL PREMIUM			**$**	**65,438.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	65,438	0.014000	$	916.00
0930	WAIVER OF SUBROGATION	65,438	1.020000	$	1,309.00
9898	EXPERIENCE MODIFICATION	67,663	0.850000	$	-10,149.00
0063	PREMIUM DISCOUNT	57,514	0.109000	$	-6,269.00
9740	TERRORISM	1,015,859	0.010000	$	102.00
	STATE TOTAL			**$**	**51,347.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
KANSAS					
UNIT: 00003 ADDRESS: 10421 W. 79TH STREET PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	340,138	8.000000	$	27,211.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	74,882	0.260000	$	195.00
8810	CLERICAL OFFICE EMPLOYEES NOC	86,495	0.120000	$	104.00
	MANUAL PREMIUM			**$**	**27,510.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	27,510	0.011000	$	303.00
0930	WAIVER OF SUBROGATION	27,510	1.020000	$	550.00
9898	EXPERIENCE MODIFICATION	28,363	0.850000	$	-4,254.00
9889	SCHEDULED DEBIT	24,109	1.050000	$	1,205.00
0063	PREMIUM DISCOUNT	25,314	0.109000	$	-2,759.00
9740	TERRORISM	501,515	0.008000	$	40.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	501,515	0.015000	$	75.00
	STATE TOTAL			**$**	**22,670.00**

Issued Date: 09/29/2019

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
LOUISIANA					
UNIT: 00004 ADDRESS: 129 NEW CAMELIA BLVD. PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	61,688	15.620000	$	9,636.00
	MANUAL PREMIUM			**$**	**9,636.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	9,636	0.014000	$	135.00
9898	EXPERIENCE MODIFICATION	9,771	0.850000	$	-1,466.00
9889	SCHEDULED DEBIT	8,305	1.050000	$	415.00
0063	PREMIUM DISCOUNT	8,720	0.109000	$	-950.00
0930	WAIVER OF SUBROGATION	8,720	1.020000	$	250.00
9740	TERRORISM	61,688	0.009000	$	6.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	61,688	0.017000	$	10.00
	STATE TOTAL			**$**	**8,036.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MINNESOTA					
UNIT: 00010 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
8742	MOBILE HOME-SALES	150,000	0.360000	$	540.00
	MANUAL PREMIUM			**$**	**540.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	540	0.011000	$	6.00
0174	MINNESOTA SPECIAL COMPENSATION FUND ASSESSMENT	677	1.034000	$	23.00
0988	REINSURANCE ASSOCIATION DEFICIENCY ASSESSMENT	677	1.000000	$	0.00
0930	WAIVER OF SUBROGATION	540	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	796	0.850000	$	-119.00
9889	SCHEDULED DEBIT	677	1.050000	$	34.00
0063	PREMIUM DISCOUNT	711	0.109000	$	-77.00
9740	TERRORISM	150,000	0.020000	$	30.00
	STATE TOTAL			**$**	**687.00**

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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MISSOURI					
UNIT: 00005 ADDRESS: 2316 E. MEYER BLVD. PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	329,790	11.220000	$	37,002.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	47,350	0.380000	$	180.00
8810	CLERICAL OFFICE EMPLOYEES NOC	66,206	0.180000	$	119.00
	MANUAL PREMIUM			**$**	**37,301.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	37,301	0.011000	$	410.00
0930	WAIVER OF SUBROGATION	37,301	1.020000	$	746.00
9898	EXPERIENCE MODIFICATION	38,457	0.850000	$	-5,769.00
9889	SCHEDULED DEBIT	32,688	1.050000	$	1,634.00
0063	PREMIUM DISCOUNT	34,322	0.109000	$	-3,741.00
MO SRG	MISSOURI WORKERS COMPENSATION PREMIUM SURCHARGE	30,616	1.030000	$	918.00
MO SSS	MO SIF SUPPLEMENTAL SCHG	30,616	1.030000	$	918.00
9740	TERRORISM	443,346	0.008000	$	35.00
	STATE TOTAL			**$**	**32,452.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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Named Insured:	HOSPITAL COURIERS, LLC
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NEVADA					
UNIT: 00006 ADDRESS: 6283 S. VALLEY VIEW BLVD. PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	70,915	11.180000	$	7,928.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	* IF ANY *	0.950000	$	0.00
8810	CLERICAL OFFICE EMPLOYEES NOC	* IF ANY *	0.290000	$	0.00
	MANUAL PREMIUM			**$**	**7,928.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	7,928	0.011000	$	87.00
0930	WAIVER OF SUBROGATION	7,928	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	8,265	0.850000	$	-1,240.00
9889	SCHEDULED DEBIT	7,025	1.050000	$	351.00
0063	PREMIUM DISCOUNT	7,376	0.109000	$	-804.00
9740	TERRORISM	70,915	0.061000	$	43.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	70,915	0.015000	$	11.00
	STATE TOTAL			**$**	**6,626.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NORTH DAKOTA					
UNIT: 00014 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	243.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	243	0.028000	$	7.00
	STATE TOTAL			**$**	**250.00**

Issued Date: 09/29/2019

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
OHIO					
UNIT: 00015 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	243.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	243	0.028000	$	7.00
	STATE TOTAL			**$**	**250.00**

Issued Date: 09/29/2019

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
Named Insured:	HOSPITAL COURIERS, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
OREGON					
UNIT: 00009 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	69,792	0.220000	$	154.00
	MANUAL PREMIUM			**$**	**154.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	154	0.004000	$	1.00
0930	WAIVER OF SUBROGATION	154	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	405	0.850000	$	-61.00
0063	PREMIUM DISCOUNT	344	0.109000	$	-37.00
OR IGA	OREGON INSURANCE GUARANTEE ASSOCIATION SURCHARGE	325	1.000000	$	0.00
OR SRG	OREGON WORKERS COMPENSATION SURCHARGE	324	1.078000	$	25.00
9740	TERRORISM	69,792	0.008000	$	6.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	69,792	0.017000	$	12.00
	STATE TOTAL			**$**	**350.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
SOUTH DAKOTA					
UNIT: 00013 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
8810	CLERICAL OFFICE EMPLOYEES NOC	* IF ANY *	0.210000	$	0.00
	MANUAL PREMIUM			**$**	**0.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	0	0.011000	$	0.00
0930	WAIVER OF SUBROGATION	0	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	250	0.850000	$	-38.00
0063	PREMIUM DISCOUNT	212	0.109000	$	-23.00
SDWCPF	SD WC INSURANCE POLICY FEE	0	1.000000	$	14.00
9740	TERRORISM	0	0.009000	$	0.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	0	0.017000	$	0.00
	STATE TOTAL			**$**	**203.00**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
TEXAS					
UNIT: 00007 ADDRESS: 6448 HWY 290 EAST PERIOD: 09/23/2019 TO 09/23/2020					
7230	TRUCKING: PARCEL OR PACKAGE DELIVERY-ALL EMPLOYEES & DRIVERS	1,730,974	6.820000	$	118,052.00
8742	SALESPERSONS, COLLECTORS OR MESSENGERS - OUTSIDE	319,931	0.170000	$	544.00
8810	CLERICAL OFFICE EMPLOYEES NOC	252,980	0.100000	$	253.00
	MANUAL PREMIUM			**$**	**118,849.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	118,849	0.014000	$	1,664.00
0930	WAIVER OF SUBROGATION	118,849	1.020000	$	2,377.00
9898	EXPERIENCE MODIFICATION	122,890	0.850000	$	-18,434.00
9889	SCHEDULED DEBIT	104,456	1.050000	$	5,223.00
0063	PREMIUM DISCOUNT	109,679	0.120000	$	-13,161.00
9740	TERRORISM	2,303,885	0.024000	$	553.00
	STATE TOTAL			**$**	**97,071.00**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
UTAH					
UNIT: 00008 ADDRESS: 1120 SPORTS PLEX DRIVE PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	251,495	7.210000	$	18,133.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	54,636	0.270000	$	148.00
8810	CLERICAL OFFICE EMPLOYEES NOC	31,582	0.120000	$	38.00
	MANUAL PREMIUM			**$**	**18,319.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	18,319	0.011000	$	202.00
0930	WAIVER OF SUBROGATION	18,319	1.020000	$	366.00
9898	EXPERIENCE MODIFICATION	18,887	0.850000	$	-2,833.00
9889	SCHEDULED DEBIT	16,054	1.050000	$	803.00
0063	PREMIUM DISCOUNT	16,857	0.109000	$	-1,837.00
9740	TERRORISM	337,713	0.007000	$	24.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	337,713	0.015000	$	51.00
	STATE TOTAL			**$**	**15,095.00**

STARR INDEMNITY
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
VIRGINIA					
UNIT: 00012 ADDRESS: 9327 MIDLOTHIAN TURNPIKE					
PERIOD: 09/23/2019 TO 09/23/2020					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	689,608	12.790000	$	88,201.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	66,465	0.270000	$	179.00
8810	CLERICAL OFFICE EMPLOYEES NOC	41,185	0.120000	$	49.00
	MANUAL PREMIUM			**$**	**88,429.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	88,429	0.011000	$	973.00
0930	WAIVER OF SUBROGATION	88,429	1.020000	$	1,769.00
9898	EXPERIENCE MODIFICATION	91,171	0.850000	$	-13,676.00
9889	SCHEDULED DEBIT	77,495	1.050000	$	3,875.00
0063	PREMIUM DISCOUNT	81,370	0.109000	$	-8,869.00
0900	EXPENSE CONSTANT			$	260.00
9740	TERRORISM	797,258	0.045000	$	359.00
	STATE TOTAL			**$**	**73,120.00**

Issued Date: 09/29/2019

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
WASHINGTON					
UNIT: 00016 ADDRESS: NO FIXED LOCATION PERIOD: 09/23/2019 TO 09/23/2020					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	243.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	243	0.028000	$	7.00
	STATE TOTAL			**$**	**250.00**

Issued Date: 09/29/2019

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
WYOMING					
UNIT: 00017 ADDRESS: 308 SOUTHWEST DRIVE PERIOD: 09/23/2019 TO 09/23/2020					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	243.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	243	0.028000	$	7.00
	STATE TOTAL			**$**	**250.00**
	POLICY TOTAL			**$**	**1,304,148.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

NAMED INSURED SCHEDULE

Loc Nbr

00001
NAMED INSURED
HCC ACQUISITION, LLC
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112-0000
FEIN: 474929823
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00001
NAMED INSURED
HOSPITAL COURIERS, LLC
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112-0000
FEIN: 383977869
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00003
NAMED INSURED
HOSPITAL COURIERS KANSAS CITY, LLC
10421 W. 79TH STREET
SHAWNEE KS 66209
FEIN: 263512654
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00005
NAMED INSURED
HOSPITAL COURIERS KANSAS CITY, LLC
2316 E. MEYER BLVD.
KANSAS CITY MO 64132
FEIN: 263512654
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00007
NAMED INSURED
HOSPITAL COURIERS AUSTIN, LLC
6448 HWY 290 EAST
AUSTIN TX 78723
FEIN: 262525858
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

Loc Nbr

00001
NAMED INSURED
HOSPITAL COURIERS CORPORATION
7200 S ALTON WAY STE A360
CENTENNIAL CO 80112-0000
FEIN: 203935156
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00002
NAMED INSURED
HOSPITAL COURIERS NEVADA, LLC
3363 PEGASUS DR
BAKERSFIELD CA 93308
FEIN: 364783266
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00004
NAMED INSURED
HOSPITAL COURIERS KANSAS CITY, LLC
129 NEW CAMELIA BLVD.
COVINGTON LA 70433
FEIN: 263512654
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00006
NAMED INSURED
HOSPITAL COURIERS NEVADA, LLC
6283 S. VALLEY VIEW BLVD.
LAS VEGAS NV 86118
FEIN: 364783266
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00008
NAMED INSURED
HOSPITAL COURIERS SALT LAKE CITY, LLC
1120 SPORTS PLEX DRIVE
KAYSVILLE UT 84037
FEIN: 204902565
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

NAMED INSURED SCHEDULE

Loc Nbr 00011

NAMED INSURED
HOSPITAL COURIERS FLORIDA, LLC
5361 NORTHWEST 33RD AVENUE
FORT LAUDERDALE FL 33309
FEIN: 812020276
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

Loc Nbr 00012

NAMED INSURED
HOSPITAL COURIERS VIRGINIA, LLC
9327 MIDLOTHIAN TURNPIKE
RICHMOND VA 23235
FEIN: 821177404
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00019

NAMED INSURED
HOSPITAL COURIERS NEVADA, LLC
1401 MARINA WAY SOUTH
RICHMOND CA 94804
FEIN: 364783266
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00020

NAMED INSURED
HOSPITAL COURIERS NEVADA, LLC
2500 MARCONI AVENUE
SACRAMENTO CA 95821
FEIN: 364783266
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00021

NAMED INSURED
HOSPITAL COURIERS NEVADA, LLC
4025 N. FRESNO ST
FRESNO CA 93726
FEIN: 364783266
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00022

NAMED INSURED
HOSPITAL COURIERS DENVER, LLC
3825 E. MULLBERRY STREET
FORT COLLINS CO 80524
FEIN: 263512717
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00023

NAMED INSURED
HOSPITAL COURIERS DENVER, LLC
3105 N. CASCADE AVENUE
COLORADO SPRINGS CO 80907
FEIN: 263512717
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00024

NAMED INSURED
HOSPITAL COURIERS DENVER, LLC
3251 REVERE STREET
AURORA CO 80011
FEIN: 263512717
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00025

NAMED INSURED
HOSPITAL COURIERS FLORIDA, LLC
12901 STARKEY ROAD
LARGO FL 33773
FEIN: 812020276
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00026

NAMED INSURED
HOSPITAL COURIERS FLORIDA, LLC
11600 NW 173RD STREET
ALACHUA FL 32615
FEIN: 812020276
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

NAMED INSURED SCHEDULE

Loc Nbr 00027

NAMED INSURED
HOSPITAL COURIERS HOUSTON, LLC
12620 WEST AIRPORT BOULEVARD
SUGARLAND TX 77478
FEIN: 263512574
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

Loc Nbr 00028

NAMED INSURED
HOSPITAL COURIERS DALLAS, LLC
631 SOUTHWESTERN BLVD
COPPELL TX 75019
FEIN: 204163048
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00029

NAMED INSURED
HOSPITAL COURIERS SAN ANTONIO, LLC
5919 W. CAMPUS DR.
SAN ANTONIO TX 78247
FEIN: 800854815
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00030

NAMED INSURED
HOSPITAL COURIERS HOUSTON, LLC
13725 NORTHWEST BLVD
CORPUS CHRISTI TX 78410
FEIN: 263512574
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

00031

NAMED INSURED
HOSPITAL COURIERS DENVER, LLC
4520 FLORENCE ST.
DENVER CO 80238
FEIN: 263512717
UNEMPLOYMENT ID#
EFFECTIVE: 09/23/2019
EXPIRATION: 09/23/2020

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00002	HOSPITAL COURIERS HOLDINGS, LLC 3363 PEGASUS DR BAKERSFIELD CA 93308
00019	HOSPITAL COURIERS HOLDINGS, LLC 1401 MARINA WAY SOUTH RICHMOND CA 94804
00020	HOSPITAL COURIERS HOLDINGS, LLC 2500 MARCONI AVENUE SACRAMENTO CA 95821
00021	HOSPITAL COURIERS HOLDINGS, LLC 4025 N. FRESNO ST FRESNO CA 93726
00001	HOSPITAL COURIERS, LLC 7200 S ALTON WAY STE A360 CENTENNIAL CO 80112-0000
00022	HOSPITAL COURIERS HOLDINGS, LLC 3825 E. MULLBERRY STREET FORT COLLINS CO 80524
00023	HOSPITAL COURIERS HOLDINGS, LLC 3105 N. CASCADE AVENUE COLORADO SPRINGS CO 80907
00024	HOSPITAL COURIERS HOLDINGS, LLC 3251 REVERE STREET AURORA CO 80011
00031	HOSPITAL COURIERS HOLDINGS, LLC 4520 FLORENCE ST. DENVER CO 80238
00032	HOSPITAL COURIERS HOLDINGS, LLC 107 W. 29TH STREET SUITE 200 LOVELAND CO 80538
00018	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY CT 99999
00011	HOSPITAL COURIERS HOLDINGS, LLC 5361 NORTHWEST 33RD AVENUE FORT LAUDERDALE FL 33309
00025	HOSPITAL COURIERS HOLDINGS, LLC 12901 STARKEY ROAD LARGO FL 33773
00026	HOSPITAL COURIERS HOLDINGS, LLC 11600 NW 173RD STREET ALACHUA FL 32615

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00003	HOSPITAL COURIERS HOLDINGS, LLC 10421 W. 79TH STREET SHAWNEE KS 66209
00004	HOSPITAL COURIERS HOLDINGS, LLC 129 NEW CAMELIA BLVD. COVINGTON LA 70433
00010	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY MN 99999
00005	HOSPITAL COURIERS HOLDINGS, LLC 2316 E. MEYER BLVD. KANSAS CITY MO 64132
00006	HOSPITAL COURIERS HOLDINGS, LLC 6283 S. VALLEY VIEW BLVD. LAS VEGAS NV 86118
00014	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY ND 99999
00015	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY OH 99999
00009	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY OR 99999
00013	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION BOX ELDER SD 57701
00007	HOSPITAL COURIERS HOLDINGS, LLC 6448 HWY 290 EAST AUSTIN TX 78723
00027	HOSPITAL COURIERS HOLDINGS, LLC 12620 WEST AIRPORT BOULEVARD SUGARLAND TX 77478
00028	HOSPITAL COURIERS HOLDINGS, LLC 631 SOUTHWESTERN BLVD COPPELL TX 75019
00029	HOSPITAL COURIERS HOLDINGS, LLC 5919 W. CAMPUS DR. SAN ANTONIO TX 78247
00030	HOSPITAL COURIERS HOLDINGS, LLC 13725 NORTHWEST BLVD CORPUS CHRISTI TX 78410

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00008	HOSPITAL COURIERS HOLDINGS, LLC 1120 SPORTS PLEX DRIVE KAYSVILLE UT 84037
00012	HOSPITAL COURIERS HOLDINGS, LLC 9327 MIDLOTHIAN TURNPIKE RICHMOND VA 23235
00016	HOSPITAL COURIERS HOLDINGS, LLC NO FIXED LOCATION NO FIXED CITY WA 99999
00017	HOSPITAL COURIERS HOLDINGS, LLC 308 SOUTHWEST DRIVE CHEYEBNNE WY 82007

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	WC000000C	1/15	WC & EL POLICY
CA	WC000404	4/84	PENDING RATE CHANGE ENDT
CA	WC000406A	7/95	PREMIUM DISCOUNT ENDT
CA	WC000419	1/01	PREMIUM DUE DATE ENDT
CA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CA	WC040301D	2/18	POLICY AMENDATORY ENDORSEMENT
CA	WC040305	1/85	CA VOLUNTARY COMPENSATION
CA	WC040306	4/84	CA WAIVER OF OUR RIGHT TO REC
CA	WC040310	1/95	CA DUTY TO DEFEND
CA	WC040421	1/08	CA OPTIONAL PREMIUM INCREASE
CA	WC040422	1/12	CA SHORT-RATE CANCELATION ENDT
CA	WC040601A	12/93	CA CANCELLATION ENDT
CA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
CA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
CO	WC000310	4/84	SOLE PROPRIETORS PARTNERS
CO	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
CO	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
CO	WC000404	4/84	PENDING RATE CHANGE ENDT
CO	WC000406	8/84	PREMIUM DISCOUNT ENDT
CO	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
CO	WC000419	1/01	PREMIUM DUE DATE ENDT
CO	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CO	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CO	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
CO	WC000425	5/17	EXPER RATING MOD FACTOR REV
CO	WC050402	11/90	CLASSIFICATION ENDT
CO	WC050403	3/93	PREM CREDIT FOR CERTIFIED RISK
CO	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
CO	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
CT	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
CT	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
CT	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
CT	WC000404	4/84	PENDING RATE CHANGE ENDT
CT	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
CT	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
CT	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
CT	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CT	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CT	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
CT	WC000425	5/17	EXPER RATING MOD FACTOR REV
CT	WC060301	4/84	CT APP OF WC INSURANCE ENDT
CT	WC060303C	7/11	CT WC FUNDS COVERAGE ENDT
CT	WC060601A	10/17	CT NONRENEWAL & RENEWAL ENDT
FL	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
FL	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
FL	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
FL	WC000404	4/84	PENDING RATE CHANGE ENDT
FL	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
FL	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
FL	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
FL	WC090303	8/05	FL EMPLOYERS LIAB COV ENDT
FL	WC090403B	1/15	FL TER RISK INS REAUTHZ DSC EN
FL	WC090407	7/13	FL NON-COOP WITH PREM AUDIT EN
FL	WC090606	10/98	FL EMPL & WAGE INFO RELEASE
FL	WC990605FL	4/13	FL ADVANCE NOTICE OF CANCELLAT
FL	WC990606FL	4/13	KNOWLEDGE OF OCCURRENCE ENDT
KS	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
KS	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
KS	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
KS	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
KS	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
KS	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
KS	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
KS	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
KS	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
KS	WC000425	5/17	EXPER RATING MOD FACTOR REV
KS	WC150401A	1/10	KS FINAL PREMIUM ENDT
KS	WC150601A	1/87	KS CANC/NON-RNL ENDT
KS	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
KS	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
LA	WC000310	4/84	SOLE PROPRIETORS PARTNERS
LA	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
LA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
LA	WC000404	4/84	PENDING RATE CHANGE ENDT
LA	WC000406	8/84	PREMIUM DISCOUNT ENDT
LA	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
LA	WC000419	1/01	PREMIUM DUE DATE ENDT
LA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
LA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
LA	WC000425	5/17	EXPER RATING MOD FACTOR REV
LA	WC170303	12/00	DUTY TO DEFEND ENDT
LA	WC170601J	8/18	LA AMENDATORY ENDT
LA	WC170602A	2/96	COST CONTAINMENT ACT
LA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
LA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
MN	WC000310	4/84	SOLE PROPRIETORS PARTNERS
MN	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
MN	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
MN	WC000406A	7/95	PREMIUM DISCOUNT ENDT

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MN	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
MN	WC000419	1/01	PREMIUM DUE DATE ENDT
MN	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
MN	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
MN	WC000425	5/17	EXPER RATING MOD FACTOR REV
MN	WC220000A	11/03	AMENDATORY ENDT
MN	WC220601D	8/06	MN CANCELLATION & NONRENEWL EN
MN	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
MN	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
MO	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
MO	WC000311A	8/91	VOLUNTARY COMP ENDT
MO	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
MO	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
MO	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
MO	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
MO	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
MO	WC000425	5/17	EXPER RATING MOD FACTOR REV
MO	WC240302	1/14	MO NOTIF OF ADDNL M B ENDT.
MO	WC240601B	1/96	MO CANC/NRN ENDT
MO	WC240602B	7/06	MO PROP & CAS GUARANTY ASSOC
MO	WC240604B	1/17	MO AMENDATORY ENDORSEMENT
MO	WC990605MO	7/12	MO ADVANCED NOTICE OF CANCELLA
MO	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
NV	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
NV	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
NV	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
NV	WC000404	4/84	PENDING RATE CHANGE ENDT
NV	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
NV	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
NV	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NV	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NV	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NV	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
NV	WC000425	5/17	EXPER RATING MOD FACTOR REV
NV	WC270601C	10/08	NV CANCELATION/NONRENEWAL ENDT
NV	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
NV	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
ND	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
ND	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
ND	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
ND	WC990636	2/18	ND AMEND END EMP LIABILITY COV
OH	WC340301C	3/10	STOP GAP EMPLOYER'S LIABILITY
OH	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
OH	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
OR	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
OR	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
OR	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
OR	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
OR	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
OR	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
OR	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
OR	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
OR	WC000425	5/17	EXPER RATING MOD FACTOR REV
OR	WC360406	10/01	OR PREMIUM DUE DATE ENDMNT
OR	WC360601E	1/08	OR CANCELLATION ENDMNT
OR	WC360604	1/17	Oregon Amendatory Endorsement
OR	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
OR	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
SD	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
SD	WC000311A	8/91	VOLUNTARY COMP & EL ENDT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
SD	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
SD	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
SD	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
SD	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
SD	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
SD	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
SD	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
SD	WC000425	5/17	EXPER RATING MOD FACTOR REV
SD	WC400601A	7/11	SD DIRECT ACTION STATUTE
SD	WC400603	1/94	SD MANAGED CARE ENDMNT
SD	WC400605B	4/06	SD CANCELLATION AND NONRENEW
SD	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
SD	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
TX	WC000311A	8/91	VOL COMP & EL COV END
TX	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
TX	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
TX	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
TX	WC000425	5/17	EXPER RATING MOD FACTOR REV
TX	WC420301I	7/17	TX AMENDATORY ENDORSEMENT
TX	WC420304B	6/14	TX WAIVER OF RIGHT TO RECOVER
TX	WC420310	1/97	TX SOLE PROP PARTNERS ENDT
TX	WC990626	9/17	ADVANCED NOTICE OF CANCELLATIO
UT	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
UT	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
UT	WC000404	4/84	PENDING RATE CHANGE ENDT
UT	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
UT	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
UT	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
UT	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
UT	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0003868	
Named Insured:	HOSPITAL COURIERS, LLC	
Agent:	CLAUDIA MANDATO	0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
UT	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
UT	WC000425	5/17	EXPER RATING MOD FACTOR REV
UT	WC430305	7/00	UT WAIVER OF SUBROGATION
UT	WC430602	7/02	UT CANCELLATION ENDORSEMENT
UT	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
UT	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
VA	WC000310	4/84	SOLE PROPRIETORS PARTNERS
VA	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
VA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
VA	WC000404	4/84	PENDING RATE CHANGE ENDT
VA	WC000406	8/84	PREMIUM DISCOUNT ENDT
VA	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
VA	WC000419	1/01	PREMIUM DUE DATE ENDT
VA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
VA	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
VA	WC000425	5/17	EXPER RATING MOD FACTOR REV
VA	WC450602	7/93	AMENDATORY ENDT
VA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
VA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
WA	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
WA	WC000404	4/84	PENDING RATE CHANGE ENDT
WA	WC990605WA	5/12	WA ADVANCED NOTICE OF CANCELLA
WA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
WY	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
WY	WC000404	4/84	PENDING RATE CHANGE ENDT
WY	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
WY	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for 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 Nonappropriated 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 1651–1654), the Federal 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.

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.

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.

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 canceled, 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 cancelation 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. **Cancelation**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation 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 cancelation 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 cancelation notice.
4. Any of these provisions that conflict with a law that controls the cancelation 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 insureds to change this policy, receive return premium, and give or receive notice of cancelation.

EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in the states shown in the Schedule.

A. Part One (Workers Compensation Insurance) does not apply to work in a state shown in the Schedule.

B. Part Two (Employers Liability Insurance) applies to work in states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.

C. Part Two (Employers Liability Insurance), C. Exclusions is changed by adding these exclusions.

This insurance does not cover

13. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of any state shown in the Schedule or otherwise fail to comply with that law.

Schedule

States

NORTH DAKOTA
WASHINGTON
WYOMING

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
Officers:	
ALL OFFICERS	COLORADO
ALL OFFICERS	KANSAS
ALL OFFICERS	LOUISIANA
ALL OFFICERS	MISSOURI
ALL OFFICERS	NEVADA
Others:	

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
Officers:	
ALL OFFICERS	UTAH
ALL OFFICERS	OREGON
ALL OFFICERS	MINNESOTA
ALL OFFICERS	FLORIDA
ALL OFFICERS	VIRGINIA
Others:	

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
Officers:	
ALL OFFICERS	SOUTH DAKOTA
ALL OFFICERS	CONNECTICUT
Others:	

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement adds Voluntary Compensation Insurance to the policy.

A. **How This Insurance Applies**

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

1. The bodily injury must be sustained by an employee included in the group of employees described in the Schedule.
2. The bodily injury must arise out of and in the course of employment necessary or incidental to work in a state listed in the Schedule.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. 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 an amount equal to the benefits that would be required of you if you and your employees described in the Schedule were subject to the workers compensation law shown in the Schedule. We will pay those amounts to the persons who would be entitled to them under the law.

C. **Exclusions**

This insurance does not cover:

1. any obligation imposed by a workers compensation or occupational disease law, or any similar law.
2. bodily injury intentionally caused or aggravated by you.

D. **Before We Pay**

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. **Recovery From Others**

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. **Employers Liability Insurance**

Part Two (Employers Liability Insurance) applies to bodily injury covered by this endorsement as though the State of employment shown in the Schedule were shown in Item 3.A. of the Information Page.

Schedule

Employees	State of Employment	Designated Workers Compensation Law
All officers and employees not subject to the workers compensation law except masters and members of the crew of any vessel.	Any state designated in item 3A of the information page of this policy.	State of hire

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

Schedule

Any person or organization to whom you become obligated to waive your rights of recovery against, under any contract or agreement you enter into prior to the occurrence of loss.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PENDING RATE CHANGE ENDORSEMENT

A rate change filing is being considered by the proper regulatory authority. The filing may result in rates different from the rates shown on the policy. If it does, we will issue an endorsement to show the new rates and their effective date.

If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State
CALIFORNIA
COLORADO
CONNECTICUT
FLORIDA
LOUISIANA
NEVADA
UTAH
VIRGINIA
WASHINGTON
WYOMING

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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

1.

State	Estimated Eligible Premium			
	First	Next	Next	Balance
COLORADO	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
CONNECTICUT	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
KANSAS	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
LOUISIANA	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____ %

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:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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

1.

State	Estimated Eligible Premium First	Next	Next	Balance
MISSOURI	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
OREGON	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
SOUTH DAKOTA	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
TEXAS	$5,000	$95,000	$400,000	$500,000
	0.0%	9.5%	11.9%	12.4%

2. Average percentage discount: _____ %

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:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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

1. State		Estimated Eligible Premium First	Next	Next	Balance
UTAH		$10,000	$190,000	$1,555,000	Over $1,755,000
		0.0%	9.1%	11.3%	12.3%
VIRGINIA		$10,000	$190,000	$1,555,000	$1,755,000
		0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____ %

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:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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 Items 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

1. State

Estimated Eligible Premium

	First $10,000	Next $190,000	Next $1,550,000	Balance
CALIFORNIA	0.0%	9.1%	11.3%	12.3%
FLORIDA	0.0%	9.1%	11.3%	12.3%
MINNESOTA	0.0%	9.1%	11.3%	12.3%
NEVADA	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

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:

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

90-DAY REPORTING REQUIREMENT—NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

You must report any change in ownership to us in writing within 90 days of the date of the change. 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. 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.

Failure to report any change in ownership, regardless of whether the change is reported within 90 days of such change, may result in revision of the experience rating modification factor used to determine your premium.

This reporting requirement applies regardless of whether an experience rating modification is currently applicable to this policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

PART FIVE
PREMIUM

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

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 due date for audit and retrospective premiums is the date of the billing.**

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (other than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (other than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of $50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
  a. It is an act that is violent or dangerous to human life, property, or infrastructure;
  b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
  c. It is an act that 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.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
CALIFORNIA	0.020000	$534.00
COLORADO	0.015000	$826.00
CONNECTICUT	0.010000	$9.00
KANSAS	0.015000	$75.00
LOUISIANA	0.017000	$10.00
NEVADA	0.015000	$11.00
OREGON	0.017000	$12.00
SOUTH DAKOTA	0.017000	$0.00
UTAH	0.015000	$51.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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 2015. 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 2015.

"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, 2015, and ending on December 31, 2020, 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 exceed:

   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible

   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.

   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.

   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.

e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.

f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, 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.

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
CALIFORNIA	0.039000	$1,042.00
COLORADO	0.007000	$385.00
CONNECTICUT	0.040000	$36.00
KANSAS	0.008000	$40.00
LOUISIANA	0.009000	$6.00
MINNESOTA	0.020000	$30.00
MISSOURI	0.008000	$35.00
NEVADA	0.061000	$43.00
OREGON	0.008000	$6.00
SOUTH DAKOTA	0.009000	$0.00
TEXAS	0.024000	$553.00
UTAH	0.007000	$24.00
VIRGINIA	0.045000	$359.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Part Five—Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge. The method for determining the Audit Noncompliance Charge by state, where applicable, is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5—Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Note:

For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
COLORADO	Estimated Annual Premium	2.00
CONNECTICUT	Estimated Annual Premium	2.00
KANSAS	Estimated Annual Premium	2.00
MINNESOTA	Estimated Annual Premium	2.00
NEVADA	Estimated Annual Premium	1.00
OREGON	Estimated Annual Premium	2.00
SOUTH DAKOTA	Estimated Annual Premium	2.00
UTAH	Estimated Annual Premium	2.00
VIRGINIA	Estimated Annual Premium	2.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT

This endorsement is added to Part Five—Premium of the policy.

The premium for the policy is adjusted by an experience rating modification factor. The factor shown on the Information Page may be revised and applied to the policy in accordance with our manuals and endorsements. We will issue an endorsement to show the revised factor, if different from the factor shown, when it is calculated.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

POLICY AMENDATORY ENDORSEMENT–CALIFORNIA

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

1. **Minors Illegally Employed – Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.

2. **Punitive or Exemplary Damages – Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.

3. **Increase in Indemnity Payment – Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars ($100).

   If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.

4. **Application of Policy.** Part One, “Workers Compensation Insurance”, A, “How This Insurance Applies”, is amended to read as follows:

   This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee’s exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.

5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.

6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.

7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.

8. Part Five, “Premium”, E, “Final Premium”, is amended to read as follows:

   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 canceled, final premium will be determined in the following way unless our manuals provide otherwise:

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

It is further agreed that this policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in this policy or such endorsements shall affect such contract or any rights, duties, or privileges arising therefrom.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective:	Policy No.:	Endorsement No.:
Insured:	Insurance Company:	

Countersigned by: _____

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT - CALIFORNIA

If the employer named in item 1 of the Information Page has in his employment persons not entitled to compensation under Division 4 of the Labor Code of the State of California, this policy shall operate as an election on the part of the employer to come under the compensation provisions of Division 4 with respect to those persons described in the Schedule below.

This policy applies to those persons described in the Schedule below as employees.

Schedule

It is agreed that if any such person is subject to the Voluntary Compensation & Employers Liability Coverage Endorsement, the Insurer will endorse the policy within 60 days of notification.

Note:

This endorsement may be used to afford compensation coverage pursuant to the Miscellaneous Regulations for the Recording and Reporting of Data, Part 2, Section IV.

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT - CALIFORNIA

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

You must maintain payroll records accurately segregating the remuneration of your employees while engaged in the work described in the Schedule.

The additional premium for this endorsement shall be 2.0% of the California workers' compensation premium otherwise due on such remuneration.

Schedule

Person or Organization	**Job Description**
Any person or organization to whom you become obligated to waive your rights of recovery against, under any contract or agreement you enter into prior to the occurrence of loss.	Where required by contract

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

DUTY TO DEFEND - CALIFORNIA

The insurance afforded by Part One, Section **C, "We Will Defend",** is hereby deleted and replaced with the following:

WE WILL DEFEND

We have the right and duty to defend at our expense any claim or proceeding against you before the California Workers' Compensation Appeals Board or its equivalent in any other state (and any appeal of a decision therefrom) for the benefits payable by this workers' compensation insurance. We have the right to investigate and settle these claims or proceedings.

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

Nothing contained in this Section shall amend, modify, restrict, or otherwise alter any obligations or conditions under Part Two - Employer's Liability Insurance of the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA

You must provide us, or our authorized representative, access to records necessary to perform a payroll verification audit. If you fail to provide access within 90 days after expiration of the policy, you are liable to pay a total premium equal to 3 times our current estimate of the annual premium for your policy. In addition, if you fail to provide access after our third request within a 90 day or longer period, you are also liable for our costs in attempting to perform the audit unless you provide a compelling business reason for your failure.

We will contact you to schedule appointments during normal business hours.

We will notify you of your failure to provide access by mailing a certified, return-receipt document stating the increased premium and the total amount of our costs incurred in our attempt(s) to perform an audit. In addition to any other obligations under this contract, 30 days after you receive the notification, you will be obligated to pay the total premium and costs referenced above. If, thereafter, you provide access to your records within three years after the policy expires, or within another mutually agreed upon time, and we succeed in performing the audit to our satisfaction, we will revise your total premium and the costs due to reflect the results of the audit.

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancelation table below:

SHORT RATE CANCELLATION TABLE

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CALIFORNIA CANCELATION ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because California is shown in Item 3.A. of the information page.

The cancelation condition in Part Six (Conditions) of the policy is replaced by these conditions:

Cancelation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy for one or more of the following reasons:
   a. Non-payment of premium;
   b. Failure to report payroll;
   c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
   d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
   e. Material misrepresentation made by you or your agent;
   f. Failure to cooperate with us in the investigation of a claim;
   g. Failure to comply with Federal or State safety orders;
   h. Failure to comply with written recommendations or our designated loss control representatives;
   i. The occurrence of a material change in the ownership of your business;
   j. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
   k. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
   l. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancelation 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. If we cancel your policy for any of the reasons listed in Items (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of cancelation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
4. The policy period will end on the day and hour stated in the cancelation notice.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

COLORADO CLASSIFICATION ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Colorado is shown in Item 3.A. of the Information Page.

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassification was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph:

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

COLORADO PREMIUM CREDIT FOR CERTIFIED RISK MANAGEMENT PROGRAMS ENDORSEMENT

This endorsement applies to Part One (Workers Compensation Insurance) because Colorado is listed in Item 3.A. of the Information Page.

The Colorado Workers Compensation Cost Containment Board has determined that a premium differential shall be provided on all policies when you have selected a designated medical provider.

If you qualify for experience and/or schedule rating and you have implemented a certified workers compensation risk management program or service, we must allow a 5% premium credit if your loss experience has improved since your last renewal date. The Schedule below will indicate if you qualify for this credit.

If you do not qualify for experience and/or schedule rating on your workers compensation insurance and you have implemented a certified workers compensation risk managment program or service, we must offer premium credits as follows:

Premium Credit	**Credit Criteria**
10%	If you have been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If you have had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If you have had two medical losses, each exceeding $250, within the last year immediately preceding the effective date of the premium credit.
4%	If you have had three medical losses, each exceeding $250, within the last year immediately preceding the effective date of the premium credit.
2%	If you have had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If you have had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

If you have selected a designated medical provider, we must allow a credit of 2.5%. If you are eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation.

If you are not eligible for experience or schedule rating, the 2.5% credit will be applied, in addition to the premium credit applicable. The combined premium credit and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%.

Schedule

% Premium Credit	Certified Risk Management Program/Designated Medical Provider

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

Section A, "How This Insurance Applies," of Part One, "Workers Compensation Insurance," is amended to read as follows:

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

1) Injury by accident must occur during the policy period.
2) Injury by disease must be caused or aggravated by exposure during the policy period to conditions of your employment.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

THE AMOUNT SHOWN ON THE INFORMATION PAGE FOR THE CONNECTICUT SECOND INJURY FUND SURCHARGE IS REQUIRED OF YOU UNDER CONNECTICUT REGULATIONS TO FINANCE THE CONNECTICUT SECOND INJURY FUND. WE WILL PAY THIS SURCHARGE TO THE CONNECTICUT STATE TREASURER.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT

This endorsement applies because Connecticut is shown in Item 3.A. of the Information Page.

Part Six—Conditions, of the policy is revised by adding the following:

F. **Nonrenewal**

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intention not to renew. Advance notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

The notice of intent not to renew will state or be accompanied by a statement specifying the reason for such nonrenewal.

G. **Renewal**

We may elect to renew the policy. In accordance with Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intent to renew if, compared to this policy, the terms or conditions of the renewal policy include any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles.

This conditional renewal notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

This conditional renewal notice will include or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Exclusion 5, Section C of Part Two of the policy, is replaced by the following: This insurance does not cover

5 bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose you immunity from civil liability under the workers compensation laws

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

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.

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "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.
3. "Insured Loss" means any loss resulting from an act of terrorism (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.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

The Act may limit 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 may not be 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 may only have to pay 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 exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
   f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United StatesGovernment would pay 80% of our Insured Losses that exceed our Insurer Deductible
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceeds $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

Rate per $100 of payroll

0.010000

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

This endorsement adds the following provisions to Part Five—Premium, G. Audit, of the policy:

We are required to complete the premium audit process no later than 90 days after policy termination. If you fail to return voluntary audit requests or refuse to cooperate in completing a final physical audit, you must pay a premium to us not to exceed three times the most recent estimated annual premium on this policy subject to the following conditions:

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.
2. We document the audit file regarding the above attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

If you do not provide all of the specific records required and if we satisfy the conditions above on or before 90 days from the date of policy termination, we may continue to try and conduct the audit and/or re-open the audit for up to three years from the date of policy termination. Alternatively, we may immediately bill you a premium not to exceed three times the most recent estimated annual premium on this policy. If you provide all of the specific records required to complete the premium audit process within the three year period, we will determine your final premium in accordance with Part Five—Premium, E. Final Premium of the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

FLORIDA
EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

KANSAS FINAL PREMIUM ENDORSEMENT

This endorsement changes how the final premium is determined. The change applies only to the premium charged because Kansas is shown in Item 3.A. of the Information Page

- Kansas final premium will not be less than the highest minimum premium for the classifications covered by this policy unless there are two or more classifications covered and the highest rated classification has less than $500 payroll.
- When this occurs the final premium will not be less than one-half of the sum of the two highest minimum premiums for any classifications covered by the policy other than Clerical Office and Salespersons.
- When the highest rated classification has less than $500 payroll and Standard Exception classifications are the only classifications showing payrolls, the final premium will not be less than the minimum premium for the classification showing the highest payroll.
- Final premium for a multiple state policy will be that of the state with the single highest minimum premium, even if that state is on an “if any” basis. If two or more states have the same highest minimum premium, the minimum premium is determined by the state with the largest amount of standard premium.
- Minimum premium is subject to final adjustment at audit and will be determined only on the basis of the classifications developing premium.
- If the final earned premium is less than the minimum premium determined at audit, then that minimum premium must be charged.
- If no classification develops premium, the final premium shall be a flat charge of $200.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

KANSAS CANCELATION AND NONRENEWAL ENDORSEMENT

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

The Cancelation Condition of the policy is replaced by these two Conditions:

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. If we cancel because you fail to pay all premium when due, we will mail or deliver to you not less than 10 days advance written notice stating when the cancelation is to take ef fect. If we cancel for any other reason, we will mail or deliver to you not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.
3. If this policy has been in effect for 90 days or more, we may cancel only for one of the following reasons:
   a. nonpayment of premium;
   b. the policy was issued because of a material misrepresentation;
   c. you violated any of the material terms and conditions of the policy;
   d. there are unfavorable underwriting factors, specific to you, that were not present when the pol- icy took effect;
   e. the Commissioner has determined that our continuation of coverage could place us in a haz- ardous financial condition or in violation of the laws of Kansas; or
   f. the Commissioner has determined that we no longer have adequate reinsurance to meet our needs.
4. Our notice of cancelation will state our reasons for canceling.
5. The policy period will end on the day and hour stated in the cancelation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice when the nonrenewal will 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.
2. Our notice of nonrenewal will state our reasons for not renewing.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

LOUISIANA DUTY TO DEFEND ENDORSEMENT

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

The duty to defend provision of the policy is replaced by this provision.

Part Two - Employer's Liability

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.

Our duty to defend ends when the limit of liability has been exhausted by the payment of a judgement or settlement.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

LOUISIANA AMENDATORY ENDORSEMENT

This endorsement applies because Louisiana is shown in Item 3.A. of the Information Page.

Part Two—Employers Liability Insurance, Section I. (Actions Against Us) of the policy is replaced by the following:

I. **Actions Against Us**

You may not bring an 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.

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

Part Five—Premium, Section E. (Final Premium) of the policy is replaced by the following:

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 that 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 calculated using one of the following methods as listed in the Schedule of this endorsement:
   a. Pro rata based on the time that this policy was in force. Final premium will not be less than the pro rata share of the minimum premium, or
   b. More than pro rata; it will be based on the time that this policy was in force, and increased by our short-rate cancellation procedure that has been filed with and approved by the commissioner. Final premium will not be less than the minimum premium.

Part Five—Premium, Section G. (Audit) of the policy is revised by adding the following:

G. **Audit**

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge, and the maximum dollar amount, is shown in the Schedule of this endorsement.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part Five—Premium, Section E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Part Six—Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. **Cancellation**

[For Home and Community-Based Services (HCBS) providers, refer to Section G. in lieu of Section D. for cancellation provisions.]*

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you at the mailing address shown on the policy or your last address of record at least 60 days before the cancellation effective date, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered at least 10 days before the effective date of cancellation.

After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:

a. Nonpayment of premium
b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
c. Activities or omissions on your part which change or increase any hazard insured against, including a failure to comply with loss control recommendations
d. Change in the risk which increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
f. Violation or breach by the insured of any policy terms or conditions
g. Such other reasons that are approved by the commissioner of insurance

2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions 1.b. through 1.g.of Section D-1 will be mailed or delivered at least 30 days before the effective date of the cancellation; notices of cancellations based on condition 1.a of Section D-1 will be mailed or delivered at least 10 days before the effective date of cancellation. The notice will state the effective date of the cancellation.
   b. We will provide you with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:
      (1) Giving notice of or specifying the reasons for a cancellation, or
      (2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement
3. We will provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.
4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or the last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the expiration date will be considered pro rata based on the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.
5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.
6. If we provide the notice described in paragraph 4 above and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.
7. We must mail or deliver to you at the mailing address shown on the policy or your last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage at least 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy’s rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first.

For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice. If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any, and other changes will be effective the day following the prior policy's expiration date.

8. Paragraph 7 does not apply to changes:
   a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business
   b. Based on the altered nature or extent of the risk insured
   c. In policy forms filed and approved with the commissioner and applicable to an entire class of business
   d. Requested by the insured
9. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the address shown in the policy, will be sufficient proof of notice.

Part Six—Conditions of the policy is revised by adding the following provision:

F. **Your Right to Remove Agent**

We will not change or remove the agent of record who wrote this policy prior to the termination or renewal of this policy unless you request the change or removal. If you request the change or removal of the agent, we will notify the agent in writing 10 calendar days in advance of the change or removal.

Schedule

1. If you cancel, final premium for this policy will be calculated: _____ pro rata, or __X__ more than pro rata

2. **Basis of Audit Noncompliance Charge** $8,036.00

   Maximum Audit Noncompliance Charge Multiplier 2.00

   Maximum Audit Noncompliance Charge $ Amount $16,072.00

[Part Six—Conditions, Section D. (Cancellation) of the policy is replaced for Home and Community-Based Services (HCBS) providers by adding Part Six—Conditions, Section G. The following cancellation provisions are to be used when the policy provides coverage to an HCBS provider and are intended to comply with Chapter 50 of the Louisiana Administrative Code, Title 48, Part I, Sections 5007, 5014, and 5015:

G. **Cancellation—Home and Community-Based Services (HCBS) Providers**

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record 60 days before any cancellation or change of coverage, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered 30 days before the effective date of cancellation. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:

a. Nonpayment of premium
b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
c. Activities or omissions on your part that change or increase any hazard insured against, including a failure to comply with loss control recommendations
d. Change in the risk that increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
f. Violation or breach by the insured of any policy terms or conditions
g. Such other reasons that are approved by the commissioner of insurance

2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions 1.a. through 1.g. of Section G-1 will be mailed or delivered 30 days before the effective date of the cancellation. The notice will state the effective date of the cancellation.
   b. We will provide you and the certificate holder (LDH Health Standards Section) with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:
      (1) Giving notice of or specifying the reasons for a cancellation, or
      (2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement
3. We will provide a notice of cancellation or a statement of reasons for cancellation to you and the certificate holder (LDH Health Standards Section) where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.
4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or your last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss-run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after the notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the policy expiration date will be considered pro rata based on the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.
5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.
6. If we provide the notice described in paragraph 4 above, and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.
7. We must mail or deliver to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or the last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy's rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first. For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice.If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any, and other changes will be effective the day following the prior policy's expiration date.

8. Paragraph 7 does not apply to changes:
   a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business
   b. Based on the altered nature or extent of the risk insured
   c. In policy forms filed and approved with the commissioner and applicable to an entire class of business
   d. Requested by the insured
9. Proof of mailing or delivery of notice of cancellation, or of nonrenewal, or of premium or coverage changes to the named insured and the certificate holder (LDH Health Standards Section) where applicable at the mailing address shown in the policy or at the last address of record, will be sufficient proof of notice.]*

* Use of bracketed [ ] provisions above indicates language only applicable to specified policies, and such bracketed language only needs to appear for the applicable policies.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

LOUISIANA COST CONTAINMENT ACT ENDORSEMENT

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

You may be eligible for a two (2) percent reduction in your premium if you attend a cost containment meeting conducted by the Occupational, Safety and Health Administration (OSHA) Section of the Office of Workers Compensation Administration. In order for you to receive the reduction, you must submit to us a certificate of attendance from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date you attended the cost containment meeting.

You may also be eligible for an additional five (5) percent reduction in your premium if you have attended a cost containment meeting and have subsequently satisfactorily implemented an occupational safety and health program prescribed by the OSHA Section. In order for you to receive the reduction, you must submit to us a Certificate of Satisfactory Implementation of Occupational, Safety and Health Program from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date of your certification.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MINNESOTA AMENDATORY ENDORSEMENT

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

E. **We Will Also Pay** is amended to read:

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. Your share of pre- or postjudgement interest assuming that the principal amount of that judgement is within the applicable policy limits under this insurance; and
5. Expenses we incur.

H. **Recovery From Others** is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

PART FIVE - PREMIUM

G. **Audit** is amended to read:

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, except as it pertains to Part Two—Employer's Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

DEFINITIONS

As used in this policy, "rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Cancellation of a New Policy

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of cancellation.

Cancellation of Other Policies

If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk in sured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

Notice of Cancellation

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or deli vered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.

Refunds Due You

If this policy is canceled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

1. Insured elsewhere;
2. Accepted replacement coverage; or
3. Requested or agreed not to renew this policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

MISSOURI NOTIFICATION OF ADDITIONAL MESOTHELIOMA BENEFITS ENDORSEMENT

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

Section 287.200.4, subdivision (3), of the Missouri Revised Statutes provides additional benefits in the case of occupational diseases due to toxic exposure that are diagnosed to be mesothelioma and result in permanent total disability or death. Your policy provides insurance for these additional benefits.

If you reject liability for mesothelioma additional benefits provided under Section 287.200.4, subdivision (3), of the Missouri Revised Statutes, you must notify us of this election. Once you notify us, we will endorse this policy to exclude insurance for these additional benefits. If you reject liability for mesothelioma additional benefits, the exclusive remedy provisions under Missouri Revised Statutes Section 287.120 shall not apply to your liability for mesothelioma additional benefits.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MISSOURI CANCELATION AND NONRENEWAL ENDORSEMENT

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

The **Cancelation** Condition of the policy is replaced by the following:

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will mail or deliver to you not less than 60 days advance written notice stating when the cancelation is to take effect and our reason for cancelation. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The 60-day notice requirement does not apply where cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;
   c. a violation of policy terms;
   d. changes in conditions after the effective date of the policy materially increasing the hazards originally insured;
   e. our insolvency;
   f. our involuntary loss of reinsurance for the policy.
4. The policy period will end on the day and hour stated in the cancelation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice stating when the nonrenewal will take effect and our reason for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
2. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. we show you our willingness to renew the policy but you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
   b. you fail to pay all premiums when due; or
   c. you obtain other insurance as a replacement of the policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOCIATION NOTIFICATION ENDORSEMENT

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

Missouri Property and Casualty Insurance Guaranty Association Coverage Limits:

1. Subject to the provisions of the Missouri Property and Casualty Insurance Guaranty Association Act (Act), if we are a member of the Missouri Property and Casualty Insurance Guaranty Association (Association), the Association will pay claims covered under the Act if we become insolvent.

2. The Act contains various exclusions, conditions and limitations that govern a claimant's eligibility to collect payment from the Association and affect the amount of any payment. The following limitation applies subject to all other provisions of the Act:
   a. Claims covered by the Association do not include a claim by or against an insured of an insolvent insurer if the insured has a net worth of more than $25 million on the later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis.

      If the insured prepares an annual report to shareholders, or an annual report to management reflecting net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurer will be used to determine net worth.

      However, the association will not:
      (1) Pay an amount in excess of the applicable limit of insurance of the policy from which a claim arises; or
      (2) Return to an insured any unearned premium in excess of $25,000.

      These limitations have no effect on the coverage we will provide under this policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MISSOURI AMENDATORY ENDORSEMENT

This endorsement applies because Missouri is shown in Item 3.A. of the Information Page.

Part Five—Premium, Section G. (Audit) of the policy is replaced by the following:

G. **Audit**

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

Audits shall be completed, billed, and premiums returned within 120 days of policy expiration or cancellation. This standard of 120 days shall not be applicable if:

1. A delay is caused by your failure to respond to reasonable audit requests provided that the requests are timely and adequately documented; or
2. A delay is by the mutual agreement of you and us provided that the agreement is adequately documented.

If you or we have any objection to the results of any audit, you or we shall have up to three years from the date of expiration or cancellation of this policy in which to send a written notice demanding a reconsideration of the audit. The written notice shall be based upon sufficiently clear and specific facts as to why the audit should be reconsidered.

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as timely and reasonably requested, we may apply an Audit Noncompliance Charge equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5—Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may also result in the cancellation of your insurance coverage, as specified under the policy and allowed under Missouri law.

Note: For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

SCHEDULE

Basis of Audit Noncompliance Charge	**Maximum Audit Noncompliance Charge Multiplier**
Estimated Annual Premium	2.00

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Part Six—Conditions, D. Cancellation of the policy is replaced by the following:

A. Midterm Cancellation

1. You may cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect.
2. We will provide you not less than 10 days notice if this policy is cancelled because you failed to pay a premium or remit an amount due because of an endorsement for a deductible when due.
3. We will provide you not less than 30 days notice for any other cancellation reason permitted under Nevada law, including failure to pay additional premium charged due to an audit of any payroll under the terms of the current or previous policy.
4. No policy of industrial insurance that has been in effect for at least 70 days or that has been renewed may be cancelled, except on any one of the following grounds:
   a. A failure by the policyholder to pay a premium for the policy of industrial insurance when due, including the failure of the policyholder to remit an amount due because of an endorsement for a deductible;
   b. A failure by the policyholder to:
      (1) Report any payroll;
      (2) Allow the insurer to audit any payroll in accordance with the terms of the policy or any previous policy issued by the insurer; or
      (3) Pay any additional premium charged because of an audit of any payroll as required by the terms of the policy or any previous policy issued by the insurer;
   c. A material failure by the policyholder to comply with any federal or state order concerning safety or any written recommendation of the insurer's designated representative for loss prevention;
   d. A material change in ownership of the policyholder or any change in the policyholder's business or operations that:
      (1) Materially increases the hazard for frequency or severity of loss;
      (2) Requires additional or different classifications for the calculation of premiums; or
      (3) Contemplates an activity that is excluded by any reinsurance treaty of the insurer;
   e. A material misrepresentation made by the policyholder; or
   f. A failure by the policyholder to cooperate with the insurer in conducting an investigation of a claim.
5. We cannot cancel the policy when the referenced reasons are corrected by you within the time specified in the written notice of cancellation.

B. Nonrenewal

1. We may elect not to renew the policy. We will provide to you a written notice of our intention not to renew at least 60 days before the expiration date.
2. We need not provide notice of our intention not to renew if you have accepted replacement coverage, if you have requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

C. Information About Claims Paid

1. If you request information for the renewal of the policy, we will provide you with information regarding claims paid on your behalf.
2. We will provide the information within 30 working days after we receive your written request. We may charge a reasonable fee for providing the information.

D. Notices

1. We will provide advance written notice of cancellation or nonrenewal as provided in A and B above. This notice must be served personally on or sent by first-class mail or electronic transmission to the employer.
2. Notices will state the effective date of the cancellation or nonrenewal and will be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal.
3. A written notice of cancellation is not required if we mutually agree with you to cancel the policy and reissue a new policy based upon a material change in the ownership or operation of your business.

E. Compliance With Law

1. Any of these provisions that conflict with a law that controls the cancellation or renewal or nonrenewal of the insurance in this policy is changed by this statement to comply with the law.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in Ohio.

A. Part One (Workers Compensation Insurance) does not apply to work in Ohio.

B. Part Two (Employers Liability Insurance) applies to work in Ohio as though it were shown in Item 3.A. of the Information Page.

C. Part Two (Employers Liability Insurance), C. **Exclusions** is changed by adding these exclusions.

C. **Exclusions**

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;

14. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of Ohio or otherwise fail to comply with that law.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OREGON PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

PART FIVE
PREMIUM

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

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 due date for audit and retrospective premiums is the date specified in the billing invoice for the policy.**

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OREGON CANCELLATION ENDORSEMENT

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

The **Cancellation** Condition of the policy is replaced by this Condition:

D. **Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancellation is to take effect. If you provide for other insurance or self-insurance, your cancellation of coverage will take effect upon the effective date of that insurance.
2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.
   a. If we cancel based on our decision not to offer insurance to all employers within your premium category, we will mail the notice of cancellation at least 90 days before the cancellation is to take effect.
   b. If we cancel for other reasons, we will mail the notice of cancellation at least 45 days before the cancellation is to take effect.
   c. If we cancel for nonpayment, we will mail notice of cancellation at least 10 days before the cancellation is to take effect.
3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.
4. The policy period will end at 12:00 midnight on the day stated in the cancellation notice.
5. When coverage is placed with another carrier as of the policy expiration date, a rejected renewal policy shall be withdrawn without charge, provided notice of nonrenewal is mailed and postmarked on or before the expiration date and is received from the insured by the insurer no later than 10 calendar days after said expiration date.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OREGON AMENDATORY ENDORSEMENT

This endorsement applies because Oregon is shown in Item 3.A. of the Information Page.

Part Two—Employers Liability Insurance, Section C. (Exclusions), Item 5. of the policy is replaced by the following:

5. Any bodily injury intentionally caused or aggravated by you, or that is the result of your engaging in conduct equivalent to an intentional tort, however defined, including as described by ORS 656.156, or other tortious conduct, or conduct or activity as described by ORS 656.018(3), such that you lose your immunity from civil liability under the workers compensation laws of Oregon;

Part Two—Employers Liability Insurance, Section C. (Exclusions) of the policy is revised by adding the following:

13. Any cause of action or remedy arising out of or under ORS 656.019 or ORS 654.305 through ORS 654.336.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

SOUTH DAKOTA DIRECT ACTION STATUTE ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because South Dakota is shown in Item 3.A. of the Information Page.

1. Your injured employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.

2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of the employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct action statute (Section 58-20-12) of the South Dakota Workers' Compensation Law.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOUTH DAKOTA MANAGED CARE ENDORSEMENT

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

This endorsement provides for the payment of benefits under the workers' compensation law of South Dakota to provide medical services and health care to injured workers for compensable injuries and diseases by means of a managed care program which meets the requirements extablished by the Department of Labor.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOUTH DAKOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is replaced by this Condition:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy.
   a. We must file a notice of intention in the office of the State Department of Labor or other officer in charge of the administration of the workers compensation law at least 10 days prior to cancellation due to nonpayment of premiums. Any policy cancelled for reasons other than nonpayment of premium requires at least 20 days notification before the effective cancellation date. This notice of intention must state the date of cancellation.
   b. We must mail or deliver to you not less than ten days advance written notice stating when the cancella tion due to nonpayment of premiums is to take effect. Any policy cancelled for reasons other than non payment of premium requires at least 20 days written notification before the effective cancellation date.
   c. Mailing that notice to you at your last known place of residence will be sufficient to prove notice.
   d. If the employer is a partnership, the notice may be given to any one of the partners.
   e. If the employer is a corporation, the notice may be given to any agent or officer of the corporation upon whom legal process may be served.
3. After sixty days from the effective date of policy issuance, a notice of cancellation may not be issued unless it is based upon at least one of the following reasons:
   a. Nonpayment of premium
   b. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Discovery of acts or omissions on the part of the named insured that increase any hazard insured against
   d. The occurrence of a change in the risk that substantially increases any hazard insured against after insurance coverage has been issued
   e. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof that substantially increases any hazard insured against
   f. A determination by the director of the Division of Insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state
   g. Violation or breach by the insured of any policy terms or conditions
   h. Such other reasons as are approved by the director of the Division of Insurance
4. The policy period will end the day and hour stated in the cancellation notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

Nonrenewal

1. We may elect not to renew. We will mail or deliver to you and your agent not less than 60 days advance written notice stating our intention not to renew this policy. Mailing notice to you at your last known address will be sufficient to prove notice.
2. A notice of nonrenewal is not required if the policyholder is transferred to an insurer that is a member of the same insurance group as the previous insurer and notice of such transfer is given in the form adopted by rule by the Division of Insurance.
3. The policy provisions control if the policy provides for a notice of refusal to renew that exceeds 60 days.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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** is amended by adding this 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. **Cancelation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancelation 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 cancelation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancelation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancelation 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 must be a cancelation 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 any 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.

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.

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

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule, but this waiver applies only with respect to bodily injury arising out of the operations described in the Schedule where you are required by a written contract to obtain this waiver from us.

This endorsement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

The premium for this endorsement is shown in the Schedule.

Schedule

1. ( ) Specific Waiver
   Name of person or organization

   (X) Blanket Waiver
   Any person or organization for whom the Named Insured has agreed by written contract to furnish this waiver.

2. Operations: All Texas Operations

3. Premium

   The premium charge for this endorsement shall be 2.0% of the premium developed on payroll in connection with work performed for the above person(s) or organization(s) arising out of the operations described.

4. Advance Premium: See Extension Page

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

Pursuant to Section 406.097, Labor Code, sole proprietors, partner(s) or corporate executive officer(s) of the named insured are covered under this workers' compensation policy, unless specifically excluded from coverage through an endorsement to the policy. Such persons may be named in the Schedule below and the premium basis for the policy shall include their remuneration.

For employees excluded from workers' compensation coverage by law, an election has been made by or on behalf of each person described in "Others" in the Schedule to be subject to the workers' compensation law of the state named in the Schedule. Such persons shall be named in the Schedule below and the premium basis for the policy shall include their remuneration.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
Officers:	
ALL OFFICERS	TEXAS
Others:	

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

UTAH WAIVER OF SUBROGATION ENDORSEMENT

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

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule. Our waiver of rights does not release your employees' rights against third parties and does not release our authority as trustee of claims against third parties.

Schedule

Any person or organization to whom you become obligated to waive your rights of recovery against, under any contract or agreement you enter into prior to the occurrence of loss.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

UTAH CANCELLATION ENDORSEMENT

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

Cancellation Section (D) of Part Six - Conditions is replaced by the following:

A. 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. If this policy has been previously renewed or has been in effect for at least 60 days, the provisions of this paragraph 2 apply. We may cancel this policy for one of the following reasons:
   a. You fail to pay all premiums when due;
   b. A material misrepresentation;
   c. A substantial change in the risk assumed, unless we should reasonably have foreseen the change or contemplated the risk when entering into the contract;
   d. Substantial breaches of contractual duties, conditions or warranties.

   We will mail or deliver to you not less than 30-days advance written notice stating when the cancella- tion is to take effect, except in the event you fail to pay your premiums when due, in which case we will mail or deliver to you not less than 10-days advance written notice stating when the cancellation is to take ef fect. Should we cancel for non-payment of premiums, we must state this as the reason for the cancella tion on our notice of cancellation. Should we cancel for any of the other reasons above, we must either state the facts on which our decision is based or notify you of your right to make a written request for that information. Mailing a cancellation notice via first class mail to you at your mailing address last known to us will be sufficient to prove notice.
3. If this policy has not previously been renewed and has been in effect less than 60 days, we may cancel the policy for any reason and without a statement of reasons. We will deliver to you not less than 10-days advance written notice stating when the cancellation is to take effect.
4. The policy period will end on the day and hour stated in the cancellation notice.

B. Renewal/Nonrenewal

1. You have the right to have the insurance renewed unless:
   a. The policy has been cancelled:
   b. The policy is expressly designated as nonrenewable;
   c. You fail to pay the renewal premium by the due date. We will mail the renewal notice to you not more than 45 days nor less than 14 days prior to the renewal effective date. The renewal notice will include the estimated renewal premium, how it may be paid, and state that failure to pay the renewal premi- um by the due date extinguishes your right to the renewal; or
   d. We give you 30-days notice of nonrenewal prior to the expiration or the anniversary date. We must deliver or send the notice by first class mail to your last known mailing address.

2. If we offer to renew the policy but on less favorable terms or at higher rates, the new terms or rates will take effect on the renewal date if we delivered or sent by first class mail to you notice of the new terms or rates at least 30 days prior of the expiration date of the prior policy. The prior notice requirement does not apply if the only change is a rate increase generally applicable to your class of business, a rate increase resulting from a classification change, or a policy form change made to make the form consistent with Utah law.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

VIRGINIA AMENDATORY ENDORSEMENT

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

For Virginia insurance, Part Six D. (Conditions - Cancelation) is replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us. You must provide written notice of your cancelation, including the date of and reasons for the cancelation, to the Workers Compensation Commission.
2. We may cancel this policy. We will provide you with 30 days notice of cancelation. We will provide the Workers Compensation Commission with immediate notice of such cancelation. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.
3. In the event of cancelation by you or us, you must provide 30 days written notice of the cancelation to your covered employees.
4. We may nonrenew your policy. We will provide 30 days notice to you and to the Workers Compensation Commission of our decision to nonrenew. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.
5. If you fail to pay the premium due on this policy, we may cancel the policy by providing 10 days notice to you and to the Workers Compensation Commission.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, non-payment of loss reimbursement or non-delivery of satisfactory security or collateral when due for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

FLORIDA ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, for which we will provide at least 10 days notice, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Under no circumstances will the number of days shown below be less than 45 days.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

MISSOURI ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, non-payment of loss reimbursement or non-delivery of satisfactory security or collateral when due for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Under no circumstances will the number of days shown below be less than 60 days.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868 00** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

WASHINGTON ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, or failure to cooperate with the terms and conditions of the policy for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

KNOWLEDGE OF OCCURRENCE ENDORSEMENT

This endorsement changes such insurance as is afforded by provision of the policy relating to the following:

Workers Compensation and Employers Liability Policy

PART FOUR – YOUR DUTIES IF INJURY OCCURS the following is added:

You must see to it that we are notified as soon as practicable of any injury which may result in a claim. Knowledge of an injury by your agent, your servant, or your employee will not in itself constitute knowledge to you unless the Director of Risk Management (or one with similar or equivalent title) or his/her designee, at the address shown in the policy declarations, will have received such notice.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

FLORIDA KNOWLEDGE OF OCCURRENCE ENDORSEMENT

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART FOUR – YOUR DUTIES IF INJURY OCCURS the following is added:

7. You must notify us as soon as practicable of any injury which may result in a claim. Knowledge of an injury by your agent, your servant, or your employee will not in itself constitute knowledge to you unless the Director of Risk Management (or one with similar or equivalent title) or his/her designee, at the address shown in the Information Page, will have received such notice.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0003868** **Effective Date:** **09/23/2019**
The Insured: **HOSPITAL COURIERS, LLC**

ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US - TEXAS

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

The following relates to **PART SIX - CONDITIONS**:

For any statutorily permitted reason other than nonpayment of premium, nonpayment of loss reimbursement or non-delivery of satisfactory security or collateral when due, we shall not provide less than the number of days advance notice set forth below. In no event shall notice be less than the number of days required by state law.

That notice will be sent certified mail or delivered to you in person.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Nonrenewal: 90 Days

All other terms and conditions of this policy remain the same.

Signed for by:

Steve Blakey, President and Chief Executive Officer

Nehemiah E. Ginsburg, General Counsel

Dallas, TX 1-866-519-2522

NORTH DAKOTA AMENDATORY ENDORSEMENT
EMPLOYERS LIABILITY COVERAGE

Policy Number: 100 0003868 **Effective Date:** 09/23/2019

Named Insured: HOSPITAL COURIERS, LLC

This endorsement changes such insurance as is afforded by provision of the policy relating to the following:

Workers Compensation and Employers Liability Policy

We agree that **PART FIVE - PREMIUM, Item G. Audit** is amended as follows:

1. Except as provided in 2. below, we may examine and audit your books and records as they relate to this policy at any time during the policy period and up to three years afterward.

2. Any audit conducted to determine the premium due or to be refunded must be completed within 180 days after:

a. The expiration date of the policy; or

b. The anniversary date, if this is a continuous policy or a policy written for a term longer than one year;

unless you agree in writing to extend the audit period.

It is also agreed that **PART SIX - CONDITIONS, D. Cancellation** item number 2 is amended as follows:

We may cancel this policy by mailing or delivering to you at the address shown on the Information Page written notice stating when A) not less than ten days thereafter in the case of Non-Payment of premium, or B) not less than 30 days thereafter, in all other cases, such cancellation shall be effective.

We may only cancel during the term of the policy for one or more of the following reasons:

a. Nonpayment of premiums;

b. Misrepresentation or fraud made by or with the knowledge of insured obtaining the policy or in pursuing a claim under the policy;

c. Actions by the insured that has substantially increased or substantially changed the risk insured;

d. Refusal of the insured to eliminate known conditions that increase the potential for loss after notification by the insurer that the condition must be removed;

e. Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

f. Loss of reinsurance by the insurer which provided coverage to the insurer for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this subsection must advise the policyholder that the policyholder has ten days from the date of receipt of the notice to appeal the cancellation to the insurance commissioner and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within five business days after receipt of the appeal;

g. A determination by the insurance commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state;

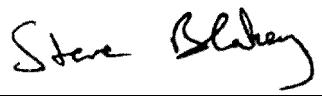
h. Nonpayment of dues to an association or organization, other than an insurance association or organization, when payment of dues is a prerequisite to obtaining or continuing such insurance; except this provision for cancellation for failure to pay dues

i. does not apply to persons who are retired at sixty-two years of age or older or to any person who is disabled according to social security standards; or

j. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property

All other terms, conditions and exclusions of the policy shall remain unchanged.

Signed for by:



Steve Blakey, President and Chief Executive Officer

Nehemiah E. Ginsburg, General Counsel and Secretary