



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (IFUB-1C68280-2-13)

RENEWAL OF (ISUB-1C68280-2-12)

INSURER: FARMINGTON CASUALTY COMPANY

NCCI CO CODE: 22640

1.

INSURED:

NIELSEN-KELLERMAN CO
21 CREEK CIRCLE
BOOTHWYN PA 19061

PRODUCER:

LOCKTON COMPANIES LLC
444 W 47TH ST STE 900
KANSAS CITY MO 64112

Insured is COMPANY

Other work places and identification numbers are shown in the schedule(s) attached.

2. The policy period is from 09-01-13 to 09-01-14 12:01 A.M. at the insured's mailing address.

3. A. **WORKERS COMPENSATION INSURANCE:** Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

PA

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: \$	500000 Each Accident
Bodily Injury by Disease: \$	500000 Policy Limit
Bodily Injury by Disease: \$	500000 Each Employee

C. **OTHER STATES INSURANCE:** Part Three of the policy applies to the states, if any, listed here:

AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI
MN MO MS MT NC NE NH NJ NM NV NY OK OR RI SC SD TN TX UT VA VT WI
WV

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All required information is subject to verification and change by audit to be made ANNUALLY.

DATE OF ISSUE: 07-22-13 KS

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC

DIRECT BILL

54274

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (IFUB-1C68280-2-13)

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 3829

	STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM \$	24970
PREMIUM DISCOUNT	774
0900-37 EXPENSE CONSTANT	200
TERRORISM	1124
CAT (OTHER THAN CERT ACTS OF TERRORISM)	375
TOTAL ESTIMATED PREMIUM	25895
TAXES AND SURCHARGES	678
DEPOSIT AMOUNT DUE	26573

Minimum Premium: \$ 320

EMPLOYERS LIABILITY MINIMUM: \$ 100

DATE OF ISSUE: 07-22-13 KS

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC 54274

COUNTERSIGNED-AGENT



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: (IFUB-1C68280-2-13)

INSURER: FARMINGTON CASUALTY COMPANY

22640-PA

INSURED'S NAME: NIELSEN-KELLERMAN CO

RATE BUREAU ID: 2708836

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 161125602 ENTITY CD 001				
NIELSEN-KELLERMAN CO				
21 CREEK CIRCLE BOOTHWYN, PA 19061				
ELECTRONIC MEASURING OR ANALYTICAL INSTRUMENT MFG.	0488	1737471	.96	16680
CLERICAL OFFICE EMPLOYEES	0953	2009168	.19	3817

PA MANUAL PREMIUM \$ 20497

1.10% EMPL. LIAB. INCREASED LIMITS(9807)	\$ 225
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	20722
EXPERIENCE MODIFICATION: 1.205 MODIFIED PREMIUM	24970
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	24970
3.10% PREMIUM DISCOUNT(0064)	774
EXPENSE CONSTANT(0900)	200
TERRORISM (9740)	1124
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	375
2.62% PA EMPL ASSESSMENT (0938)	678
TOTAL ESTIMATED PREMIUM	26573
DEPOSIT AMOUNT DUE	26573

DATE OF ISSUE: 07-22-13 KS

SCHEDULE NO: 1 OF LAST



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (IFUB-1 C68280-2-13)

LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE

We agree that the following listed endorsements form a part of this policy on its effective date.

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 00 04 22 A - 001	TERRORISM-REAUTHORIZATION ACT DISCLOSURE
WC 00 04 21 C - 001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT
WC 99 04 08 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 37 06 01 00 - 001	SPECIAL PA ENDT -- INSPECTION OF MANUALS
WC 37 06 02 00 - 001	NOTICE INS CONSULTATION SERVICE EXEMPT.
WC 37 06 03 A - 001	PA ACT 86-1986 ENDORSEMENT
WC 37 06 04 00 - 001	PA EMPLOYER ASSESSMENT ENDORSEMENT



The Travelers Insurance Companies

(Each a Stock Insurance Company)
Hartford, Connecticut

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 dis-

ease 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 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945), 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 USC Sections 51-60), 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.
11. Fines or penalties imposed for violation of federal or state law.
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) 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 judgement 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 judgement.

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 cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

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

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports,



payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period

ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX – CONDITIONS

A. Inspection

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation


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

E. Sole Representative

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

In witness whereof, the company has caused this policy to be signed by its President and Secretary at Hartford, Connecticut and countersigned on the Information page by a duly authorized agent of the company.


Secretary


President

POLICY NUMBER: (IFUB-1C68280-2-13)

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 2007. 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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, 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, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.

"Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed \$100,000,000,000 in a Program 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.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 22 (A)**

POLICY NUMBER: (IFUB-1C68280-2-13)

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed \$100,000,000 in a Program Year, the United States Government would pay 85% 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
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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
Insured

Policy No.

Endorsement No.
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 A), 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

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
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 07-22-13

ST ASSIGN:

Page 1 of 1



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 99 04 08 (00)**

POLICY NUMBER: (IFUB-1C68280-2-13)

PREMIUM DISCOUNT ENDORSEMENT

The premium for the state and other states, if any, listed in item 3.A of the Information Page may be eligible for a discount. The final calculation of premium discount will be determined by our manuals and your premium as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

OTHER POLICIES:



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 19 (00)

POLICY NUMBER: (IFUB-1C68280-2-13)

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.**





**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 37 06 01 (00)

POLICY NUMBER: (IFUB-1 C68280-2-13)

SPECIAL PENNSYLVANIA ENDORSEMENT – INSPECTION OF MANUALS

The manuals of rules, rating plans, and classifications are approved pursuant to the provisions of Section 654 of the Insurance Company Law of May 17, 1921, P.I. 682, as amended, and are on file with the Insurance Commissioner of the Commonwealth of Pennsylvania.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 02 (00)

POLICY NUMBER: (IFUB-1C68280-2-13)

**NOTICE
INSURANCE CONSULTATION SERVICES EXEMPTION ACT**

This notice is issued by that member of The Travelers Insurance Companies which issued your insurance policy and shall be attached to and become a part of your policy.

This Notice is provided to you pursuant to the law of the Commonwealth of Pennsylvania effective January 1, 1981 and known as the "Insurance Consultation Services Exemption Act", which generally provides that "the furnishing of, or failure to furnish, insurance consultation services related to, in connection with or incidental to a policy of insurance shall not subject the insurer, its agents, employees or service contractors to liability for damages from injury, death or loss occurring as a result of any act or omission by any person in the course of such services."

Such immunity does not apply: (I) where the injury occurred during the actual performance of consultation services and was caused by the negligence of the insurer; (II) with respect to consultation services performed pursuant to a written service contract not incidental to a policy of insurance; and (III) in any action against an insurer in which it is judicially determined that any act or omission resulting in damages constituted a crime, actual malice or gross negligence.

The Travelers may make such inspection in accordance with provisions of our policies.



DATE OF ISSUE: 07-22-13 ST ASSIGN:

POLICY NUMBER: (IFUB-1C68280-2-13)

**PENNSYLVANIA ACT 86-1986 ENDORSEMENT
NONRENEWAL, NOTICE OF INCREASE OF PREMIUM, and RETURN OF
UNEARNED PREMIUM**

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

The policy conditions are amended by adding the following regarding nonrenewal, notice of increase in premium, and return of unearned premium.

Nonrenewal

1. We may elect not to renew the policy. We will mail to each named insured, by first class mail, not less than 60 days advance notice stating when the nonrenewal will take effect. Mailing that notice to you at your mailing address last known to us will be sufficient to prove notice.
2. Our notice of nonrenewal will state our specific reasons for not renewing.
3. If we have indicated our willingness to renew, we will not send you a notice of nonrenewal. However, the policy will still terminate on its expiration date if:
 - a. 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.

Notice of Increase in Premium

1. We will provide you with not less than 30 days advance notice of an increase in renewal premium of this policy, if it is our intent to offer such renewal.
2. The above notification requirement will be satisfied if we have issued a renewal policy more than 30 days prior to its effective date.
3. If a policy has been written or is to be written on a retrospective rating plan basis, the notice of increase in premium provision of this endorsement does not apply.

Return of Unearned Premium

1. If this policy is canceled and there is unearned premium due you:
 - a. If the Company cancels, the unearned premium will be returned to you within 10 business days after the effective date of cancellation.
 - b. If you cancel, the unearned premium will be returned within 30 days after the effective date of cancellation.
2. Because this policy was written on the basis of an estimated premium and is subject to a premium audit, the unearned premium specified in 1a. and 1b. above, if any, shall be returned on an estimated basis. Upon our completion of computation of the exact premium, an additional return premium or charge will be made to you within 15 days of the final computation.
3. These return of unearned premium provisions shall not apply if this policy is written on a retrospective rating plan basis.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 37 06 04 (00)

POLICY NUMBER: (IFUB-1C68280-2-13)

PENNSYLVANIA

EMPLOYER ASSESSMENT ENDORSEMENT

Act 57 of 1997 requires that "...the assessments for the maintenance of the Subsequent Injury Fund, the Workmen's Compensation Supersedes Fund and the Workmen's Compensation Administration Fund under sections 306.2, 443 and 446 of the act of June 2, 1915 (P.L. 736, No. 338), known as the "Workers' Compensation Act, shall be imposed, collected and remitted through insurers in accordance with regulations promulgated by the Department of Labor and Industry".

EMPLOYER ASSESSMENT FORMULA:

Employer = Act 57 of 1997 Employer X Employer Assessment
Assessment Assessment Factor Premium Base

Act 57 of 1997 Employer Assessment Factor

A factor expressed to four decimal places proposed by the Pennsylvania Compensation Rating Bureau and approved by the Pennsylvania Insurance Commissioner.

Employer Assessment Premium Base

Calculation of Employer Assessment Premium Base proceeds by adding back to the total policy premium the amount of any Small Deductible Premium Credit or Large Deductible Premium Credit.

Code 0938

EMPLOYER ASSESSMENT
FACTOR

See info page

EMPLOYER ASSESSMENT

\$ See info page




If Your Employee Is Injured At Work

Prompt reporting of work-related injuries and illnesses and the use of Travelers national Medical Network Providers can achieve better outcomes and lower your overall workers compensation claim costs!

Whenever an Employee suffers a work-related injury or illness, the Employer should:

1. Seek appropriate medical care for the Employee.
2. If the injury or illness is acute, the Employer should always send the Employee to the nearest medical emergency department.
3. If the injury or illness is not acute, the Employer may suggest that the Employee seek treatment from the nearest Medical Network Provider. Medical Network Providers understand work-related illnesses and injuries, are credentialed to help assure quality care, and cooperate to achieve a medically appropriate return to work for the Employee. Medical Network Providers (hospitals, initial care clinics, specialists, testing, therapy, etc.) are available in all 50 States and the District of Columbia. Even before an illness or injury occurs, it may be helpful for the Employer to build a relationship with a convenient Medical Network Clinic or Hospital that will provide initial treatment for ill or injured Employees.
4. The Employee's Supervisor should gather pertinent facts about the work-related illness or injury and may use the Worksheet For Workers' Compensation Telephone Reporting provided by Travelers as a guide.
5. As soon as possible, the Employer should report all work-related illnesses or injuries to Travelers by,
 - using Travelers business insurance online reporting web site at travelers.com
 - dialing our toll free number, **1-800-238-6225**. If needed at that time, Travelers Customer Service Representative can provide the name of a convenient Medical Network Provider. Prompt reporting of work-related illnesses and injuries is key in helping to reduce total claim costs. At the conclusion of the phone call, the Travelers Customer Service Representative will provide a claim number that should be retained for the Employer's reference and also provided to the ill or injured Employee.

The card below contains information that may be helpful in reporting work-related illnesses and injuries to Travelers and should be kept in a convenient location for use by the Employer when needed.

 WC Claim Reporting	
<ul style="list-style-type: none">• Promptly report your work-related injuries to Travelers:<ul style="list-style-type: none">• Travelers.com• 800-238-6225• Learn about Travelers unique Claim Services and find a convenient medical network provider by logging on to Travelers.com.• To get to Travelers website, select Business Insurance from the home page. Then choose Workers' Compensation & Managed Care Claim Management from the menu of services in the left margin. Finally, click on Preferred Provider Network to search for a Medical Network Provider near you.	

WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT/ACCIDENT INFORMATION

CALLER'S PHONE NUMBER/EXTENSION ()	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED			
PARENT COMPANY/INSURED'S NAME			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY		TIME OF INJURY	
ACCIDENT DESCRIPTION			

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	
EMPLOYEE'S HOME PHONE NUMBER ()	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	INJURED WORKER TYPE	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS

HOURS/DAY

DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION

\$ _____ /HOUR OR \$ _____ /ANNUAL OR \$ _____ /WEEKLY OVERTIME: \$ _____ ADDITIONAL BENEFITS: \$ _____

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME

SUPERVISOR'S PHONE NUMBER:
()

BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)		
EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED		
DO YOU QUESTION THE VALIDITY OF THE CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
WITNESS INFORMATION/OTHERS INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

☐ FIRST AID —TREATMENT AND DATE OF 1st TREATMENT

☐ HOSPITAL/
CLINIC —NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1st TREATMENT, LENGTH OF STAY AMBULANCE USED?

WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?

☐ YES ☐ NO

WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATENT?

☐ YES ☐ NO

☐ PHYSICIAN —

**SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR
YOUR INDIVIDUAL STATE.**

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

Alabama

Employee's County:
Return to work (Y/N):
At what Occupation:
At what Wage \$:
Return to work wage is per (Day, Week or Month):
Employer's ID (U.C. Account) Number:
What Specific Product(s) does the business produce:

Alaska - No Additional State Questions

Arizona

Last Day of Work after injury:
Number of Days per Week Company usually Works:
Department Number:
If Validity of Claim is Doubtful, state Reason:
Has injured been employed for more than 12 months (Y/N):
Was employee on overtime when injured (Y/N):

Arkansas - No Additional State Questions

California

State Unemployment Insurance Account Number:
Date employee was provided Employee Claim Form:
Has your employee pre-designated a primary treating physician (Y/N):
If Yes, Primary Treating Physicians
First Name: Last Name: Street Address:
City: State: Zip: Phone:
If No, did your employee require medical treatment (Y/N):
If Yes, Treating Physicians
First Name: Last Name: Phone:
If No, and employee requires medical treatment in the future, you can go to our website WWW.MYWCOMPINFO.COM to find a provider in the Medical Provider Network.

Colorado

Employer Federal ID Number
Does Employer have a salary continuation program (Y/N)
If "Yes" is this program registered with the state (Y/N)

Connecticut - No Additional State Questions

Delaware

Employer's UC Reporting Number:
Employees County:
Returned to work (Y/N): If Yes, at same wage (Y/N):

District of Columbia

Employer ID Number:
Returned to work (Y/N):
If Yes, at what Time: AM/PM
At what Wage \$: Per (Day, Week or Month):
Was injured hired in DC (Y/N):
Was employee in his/her regular occupation when injured (Y/N):
Was injured given Form #7 DCWC (Y/N):
Piece or Time Worker (piece, time or blank):

Florida - No Additional State Questions

Georgia

Wage Rate at time of injury \$: Per:
First Date employee failed to work a full day:
Did employee work the next day (Y/N):
Return to work Wage \$:
Return to work wage is per (Day, Week or Month):

Hawaii

Was employee furnished meals or lodging (Y/N):

Idaho - No Additional State Questions

Illinois

Has the injured worker signed a medical authorization (Y/N):
If yes, inform them to please fax the signed medical authorization to the med auth customer service specialist at 1-877-786-5567.

Indiana - No Additional State Questions

Iowa - No Additional State Questions

Kansas

SIC Code:
Was worker admitted to hospital (Y/N):
If Yes, Date of Admission:
Was worker treated in emergency room only (Y/N):
Returned to work (Y/N):
If employee has returned to work, was return to light duty (Y/N):
Is further medical aid needed (Y/N):
Is compensation now being paid (Y/N):
If Yes, Date of first Initial Payment:
Fatal (Y/N):
If Yes, Name and Address of Dependents:

Kentucky - No Additional State Questions

Louisiana

Employer's Federal ID Number:
Employer's Unemployment Insurance Reporting Number:
Returned to work (Y/N):
If Yes, at same wage (Y/N):
Last Full Day Paid:
If occupational disease, Date of Initial Diagnosis:
Parish (county) where injury occurred:

Maine

Employer's State Unemployment Insurance Account Number (UIAN):
Federal Employer Insurance Number (FEIN):

Maryland - No Additional State Questions

Massachusetts

Federal ID Number:
Returned to work (Y/N):
Did employee return to his/her regular occupation (Y/N):
Describe nature of business or article manufactured (S=Service, W=Wholesale, R=Retail, M=Manufacturing):
Date Reported as work related:

Michigan

Federal ID Number:

Minnesota

Date employer notified of lost time:
NAICS Code Number:

Mississippi - No Additional State Questions

Missouri - No Additional State Questions

Montana - No Additional State Questions

Nebraska - No Additional State Questions

Nevada

How long employed by you in Nevada Years: Months:
If Validity of Claim is Doubtful, state Reason:

New Hampshire

Federal I.D. Number:
Was the employee injured in his/her regular occupation (Y/N):
Was injured hired in New Hampshire (Y/N):
Number of Full-Time Employees:
Number of Part-Time Employees:
If leased or temporary worker, provide the Client's Business Name:
Was accident caused by injured's failure to use safeguards or follow regulations (Y/N):
Probable Length of Disability:
Returned to work (Y/N):
At what Occupation:
Returned at Full Duty:
Returned at Alternative/Light Duty:
Initial treatment ("X" all that apply)
No medical treatment: Care provided by employer only (on-site): Emergency Care: Hospitalized: Outpatient: Clinic:
Office Visit: Other-explain:
Is there a managed care program (Y/N):

WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

If Yes, Name of Provider:

Is there a written safety program in force (Y/N):

Is there an active safety committee (Y/N):

Employee's Legal First Name (please validate):

New Jersey - No Additional State Questions

New Mexico - No Additional State Questions

New York

Did you provide medical care (Y/N):

If Yes, When:

Returned to work (Y/N):

If Yes, at what Weekly Wage \$:

Injured workers Work Week (indicate days regularly worked):

Fatal (Y/N):

If Yes, Name and Address of nearest relative:

Relationship:

North Carolina

Regular Wages per Day \$:

Average Weekly Wages with Overtime \$:

Returned to work (Y/N):

If Yes, at what Time: AM/PM

If Yes, what Date:

Return to work at what Wage \$: Per (Day, Week or Month):

Return to work at what Occupation:

North Dakota - No Additional State Questions

Ohio

Time Accident Reported to employer: AM/PM:

Has employee ever filed a previous application for this injury (Y/N):

Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):

If Yes, specify Claim Number and Body Parts:

Employee's County:

Current Employer's Risk Number:

Oklahoma

Was employment agreement made in Oklahoma (Y/N):

SIC Number:

Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):

Oregon

Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):

Was accident caused by failure of machinery or product (Y/N):

Did someone (not worker) cause accident (Y/N):

Time worker left work: AM/PM:

Pennsylvania

Employee's County:

Bureau Code:

NAICS Code:

Employer's County:

Are you aware of a 'Panel of Physicians' for your Employer? (Y/N)

Rhode Island

Federal ID Number:

First Full Day Lost from work:

Unemployment Insurance Number:

State of Hire:

Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):

If Yes, Date Employer first Notified of medical treatment or lost time:

Category of Injury or Illness ("X" all that apply):

Injury: Illness: Occupational Disease: Repetitive Trauma:

Occupational Hearing Loss: Unknown:

South Carolina - No Additional State Questions

South Dakota

Federal ID Number:

Number of employees:

Body Part Injured Code (2 digits):

Cause of Injury Code (2 digits):

Nature of Injury Code (2 digits):

Was employee hired for temporary employment (Y/N):

Carrier Code:

Tennessee - No Additional State Questions

Texas - No Additional State Questions

Utah - No Additional State Questions

Vermont

Federal ID Number:

Was employee hired in Vermont (Y/N):

Does the employer regularly employ 10 or more employees (Y/N):

Returned to work (Y/N): If Yes, at what Weekly Wage \$:

Was injured paid in full for the date disability began (Y/N):

Was employee injured at his/her regular occupation (Y/N):

Fatal (Y/N):

If Yes, Name, Address and Relationship of Nearest Relative:

Last Date Paid in Full:

Virginia

Returned to work (Y/N): If Yes, at what Wage \$:

Federal Tax ID Number:

Washington - No Additional State Questions

West Virginia

Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)

Wisconsin - No Additional State Questions

Wyoming - No Additional State Questions

U.S. Longshoremans (USDOL) - No Additional State Questions



PRIVACY NOTICE

THE TRAVELERS INSURANCE COMPANIES

PRIVACY POLICY

Thank you for selecting THE TRAVELERS INSURANCE COMPANIES as your workers compensation insurer. At THE TRAVELERS INSURANCE COMPANIES a subsidiary of Travelers, we recognize that privacy is important to you. That is why we are committed to protecting your privacy through the adoption of the following privacy principles:

Collection Of Information

We collect, retain, and use information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, only where we believe that it will help or is necessary to provide you products and services or otherwise conduct our business. We collect nonpublic personal financial information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, from the following sources:

- information we receive from you or through your agent or broker on applications or other forms;
- information we receive from or about you in the process of adjusting claims;
- information about your other transactions, including risk control and other consulting services, with us, our affiliates or other third parties;
- information about your coverages and loss activity with other carriers; and
- information we receive from a consumer reporting agency.

Such information includes identifying information such as policyholder, participant, beneficiary or claimant name, address, and social security number; financial information such as income, payment history, or credit history; and, under certain circumstances, health information such as information about an illness, disability, or injury. It could also include information on claims with other insurance companies and us and the condition and maintenance of your property.

Disclosure Of Information

We usually do not disclose nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, without your consent. However, in some circumstances we may disclose information to others without your prior authorization. The most common disclosures are to the following persons:

- our affiliated property and casualty insurance companies;
- state insurance departments, for their regulation of our business;
- other government authorities;
- our agents and brokers as necessary to conduct our business;
- organizations that perform underwriting and claims investigations;
- another insurance company to which you have applied for a policy or submitted a claim;
- insurance support agencies, law enforcement agencies and our reinsurers; and
- any other third party, as permitted or required by law.

Most importantly, THE TRAVELERS INSURANCE COMPANIES does not and will not disclose or sell nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to anyone for marketing purposes.

Confidentiality And Security

We restrict access to nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to those who need it to serve your insurance needs and to maintain and improve customer service. We maintain physical, electronic, and procedural safeguards that comply with federal and state laws and regulations to guard your nonpublic personal information.

Disclosure and Protection of Former Customers' Information

We may disclose all the personal information we have collected, as described above. However, even if you no longer have a customer relationship with us, we will continue to follow our privacy policies and practices to protect your information.

Changes In Privacy Policy

We may choose to modify our policy regarding the treatment of personal information at any time. Before we do so, we will notify you and provide an updated privacy notice.

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

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RIGHTS AND DUTIES FORM – SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be at your expense for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name

Employee Signature

Date

See reverse for a complete text of Section 306 (f.1)(1)(i)

If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM – SIDE 2

PENNSYLVANIA WORKERS' COMPENSATION ACT SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

WORKERS' COMPENSATION INFORMATION

Pennsylvania

THANK YOU FOR YOUR BUSINESS

We look forward to partnering with you in your Workers Compensation program.

The following will introduce you to Claim related forms and medical provider information that you need to be familiar with.

1. Forms – There are two forms that need to be signed by your employees, before an accident ever happens.
 - A. **Workers Compensation Information Form.** Please have your employees sign this form when you receive this letter, and again at the time of any reported accident or incident. Be sure that this form is also signed by all newly hired employees. The two signatures (form signed at time of hire and form signed at time of reported accident) are required to comply with current guidelines set forth by the Pennsylvania Workers Compensation Bureau.
 - B. **Pennsylvania Rights and Duties.** Please have your employees sign this form shortly after receiving your policy packet, as well as at the time of any workers compensation accident or incident. This assures that your employees treat with a recommended network medical provider for the first 90 days following an injury when you have posted a List of Network Providers.
2. List of Network Medical Providers – This is also known as a "panel" list.
 - A. **Benefits:** Using a panel list provides you the opportunity to direct your employees for the first 90 days of a claim to a recommended network medical provider that is familiar with the workers compensation program, if you get the Rights and Duties signed. Using this panel list helps your employee to return to work and helps you by reducing the overall cost of the workers compensation claim.

"Why not let people treat where they want?" Many family doctors or health care providers are not familiar with the workers compensation process and fail to properly address issues that we need them to address, such as medical causation and work status.

We recommend that you implement and post a panel list and have your employees sign the two forms to ensure the best possible outcome for your workers compensation claim. We feel it is important that you prepare for a claim event before it happens.



WORKERS' COMPENSATION INFORMATION Pennsylvania

To all employees:

The workers' compensation law in Pennsylvania provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-25
Telephone number within Pennsylvania: 800-482-2383
Telephone number outside of this Commonwealth: 717-772-4447
TTY- 800-362-4228 (for hearing and speech impaired only)

www.state.pa.us, PA Keyword: workers comp.

I, _____, employee of _____ (employer), certify that I received, read, and understood the information provided above on my date of hire _____ (date).

If applicable, I, _____, employee of _____ (employer), certify that I received, read, and understood the above information on _____ (the date of work-related injury or disease).

POLICY NUMBER: (IFUB-1C68280-2-13)

**NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE
FOR PENNSYLVANIA WORKERS' COMPENSATION MEDICAL AND INDEMNITY BENEFITS**

Pennsylvania Policyholders

Pennsylvania law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of \$1,000 and a maximum of \$10,000 per claim, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible for medical benefits.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement (WC 37 04 03 (00)) will then be attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available please contact your producer.

DEDUCTIBLE TABLE

DEDUCTIBLE PER ACCIDENT:	\$1,000	\$5,000	\$10,000
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Yes, I want a deductible of \$_____ applied to my medical and indemnity benefits under the Pennsylvania Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

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I understand that in accordance with Pennsylvania revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer's Name: _____

Policy Number: _____