TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEW YORK SECURITY FUND SURCHARGE

Dear Policyholder:

"Companies writing workers compensation insurance business in New York are required to participate in the New York Workers' Compensation Security Fund. If a company becomes insolvent, the security fund settles unpaid claims and assesses each insurance company for its fair share.

New York law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged "NY surcharge", an amount will be displayed on your premium notice."

DATE OF ISSUE: **06-25-15**

W31N2E04

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 17 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE

Employee Insured by General Employer Excluded

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

NO LIABILITY FOR EMPLOYEE INSURED BY GENERAL EMPLOYER

Any liability you may have as the special employer of an employee who is not on your payroll at the time of injury, based upon your representation that: (1) you have entered into a valid and enforceable agreement pursuant to Labor Code Section 3602 (d) with the employee's general employer under which the general employer agrees to secure the payment of compensation for such employee and (2) the general employer has obtained workers' compensation coverage for the employee.

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES, AND OTHER SUBSTANTIAL PENALTIES (Labor Code Section 3710.1, et seq.).

By signature below, you affirm that, with respect to any employee who is also the employee of a general employer, (1) you have entered into a valid and enforceable agreement pursuant to Labor Code Section 3602(d) with the employee's general employer under which the general employer agrees to secure the payment of compensation for such employee and (2) the general employer has obtained workers' compensation coverage for the employee.

Countersigned By _____

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 _____

TRAVELERS

Report Claims Immediately by Calling*
1-800-238-6225
Speak directly with a claim professional
24 hours a day, 365 days a year

*Unless Your Policy Requires **Written** Notice or Reporting

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

A Custom Insurance Policy Prepared for:

BC TECHNICAL, INC.
7172 S AIRPORT RD
WEST JORDAN UT 84084

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (HJUB-6E20721-A-15)

NJ TAX IDENTIFICATION NO.: 870550892000 **RENEWAL OF (HJUB-6E20721-A-14)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

NCCI CO CODE: 13579

1.

INSURED:

BC TECHNICAL, INC.
7172 S AIRPORT RD
WEST JORDAN UT 84084

PRODUCER:

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

Insured is **A CORPORATION**

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

2. The policy period is from **06-06-15** to **06-06-16** 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:

AL AZ CA CO CT FL GA IL IN KS KY LA MA MD MI MN MO NC NE NJ NV NY OK OR PA SC TN TX UT VA WI

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:	**$**	**1000000**	Each Accident
Bodily Injury by Disease:	**$**	**1000000**	Policy Limit
Bodily Injury by Disease:	**$**	**1000000**	Each Employee

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

AR DC DE HI IA ID ME MS MT NH NM RI SD VT 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: 06-25-15 DS
OFFICE: ST LOUIS 184
PRODUCER: LOCKTON COMPANIES LLC 54274

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 3841 NAICS: 339112

		STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	$	105686
PREMIUM DISCOUNT		5993
OTHER CHARGES & CREDITS		396
0900-12 EXPENSE CONSTANT		280
TERRORISM		3694
CAT (OTHER THAN CERT ACTS OF TERRORISM)		1469
TOTAL ESTIMATED PREMIUM		105136
TAXES AND SURCHARGES		3306
DEPOSIT AMOUNT DUE		108442

Minimum Premium: $ 1000 **EMPLOYERS LIABILITY MINIMUM: $ 150**

OTHER MINIMUMS ARE INDICATED ON THE APPLICABLE SCHEDULE(S)

DATE OF ISSUE: **06-25-15 DS**
OFFICE: **ST LOUIS 184**
PRODUCER: **LOCKTON COMPANIES LLC 54274**

COUNTERSIGNED-AGENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-AL

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
5934 STONEBRIAR TRACE PINSON, AL 35126 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR (COUNTY/TOWN CODE 9999)	**5191**	**126519**	**.90**	**1139**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
10927 ELYSIAN CIRCLE DAPHNE, AL 36526 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR (COUNTY/TOWN CODE 9999)	5191	IF ANY	.90	
CLERICAL OFFICE EMPLOYEES NOC (COUNTY/TOWN CODE 9999)	8810	152462	.17	259

AL MANUAL PREMIUM $ 1398

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 20
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	1418
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	1219
25.00% SCHEDULE CREDIT (9887)	305
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	914
4.60% PREMIUM DISCOUNT(0064)	42
TERRORISM (9740)	28
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	28
TOTAL ESTIMATED PREMIUM	928
DEPOSIT AMOUNT DUE	928

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-AZ

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
7212 W DREYFUS DR PEORIA, AZ 85381 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**235809**	**.87**	**2052**
LOCATION 002 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
6100 W GILA SPRINGS PLACE #1 & #3 CHANDLER, AZ 85226 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	158488	.87	1379
LOCATION 003 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
3501 E ELIDA STREET TUCSON, AZ 85716 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	186992	.44	823

AZ MANUAL PREMIUM $ 4254

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 47
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	4301
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	3700
DEVIATION PROGRAM CREDIT (9034) - 40.00%	1480
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	2220
8.20% PREMIUM DISCOUNT (0063)	182
TERRORISM (9740)	59
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	59
TOTAL ESTIMATED PREMIUM	2156
DEPOSIT AMOUNT DUE	2156

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **050**
13579-CA

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 001621542

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1818 BLACK BEAR MOUNTAIN CT MARIPOSA, CA 95338 SIC CODE: 3841 NAICS: 339112				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**336572**	**.43**	**1447**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
17 MONTE VERANO CT SAN JOSE, CA 95116 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
11435 PLANE TREE RD FONTANA, CA 92337 SIC CODE: 3841 NAICS: 339112				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
13640 SAN ANTONIO AVE CHINO, CA 91710 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 005 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
11657 FONTANELLE CT SAN DIEGO, CA 92128 SIC CODE: 3841 NAICS: 339112				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 006 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
35767 VIA LAS RAMBLAS TEMECULA, CA 92592 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 01 (CONT'D)				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**871259**	**1.69**	**14724**
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	

LOCATION 007 01

FEIN 870550892 ENTITY CD 001

BC TECHNICAL, INC.

19 SHARON LN
COTO DE CAZA, CA 92679
SIC CODE: 3841 NAICS: 339112

INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	

LOCATION 008 01

FEIN 870550892 ENTITY CD 001

BC TECHNICAL, INC.

3950 MACK RD #226
SACRAMENTO, CA 95823
SIC CODE: 3841 NAICS: 339112

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 008 01 (CONT'D)				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 009 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
24633 VALLEY ST NEWHALL, CA 91321 SIC CODE: 3841 NAICS: 339112				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	**5128**	**IF ANY**	**1.69**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.43**	
LOCATION 010 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
2129 AUDUBON CT FAIRFIELD, CA 94533 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 010 01 (CONT'D)				
INSTRUMENT-PROFESSIONAL OR SCIENTIFIC-INSTALLATION SERVICE OR REPAIR-AWAY FROM SHOP-NOT OFFICE MACHINES	5128	IF ANY	1.69	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.43	
LOCATION 011 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
432 N MYRTLE AVE MONROVIA, CA 91016 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS-OUTSIDE	8742	7115	.56	40
LOCATION 012 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
34642 AVENUE 13 1/4 MADERA, CA 93636 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 012 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR-N.O.C.-SHOP AND OUTSIDE	5191	112461	2.32	2609

CA MANUAL PREMIUM $ 18820

TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$ 18820
EXPERIENCE MODIFICATION: .92 MODIFIED PREMIUM	17314
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	17314
3.40% PREMIUM DISCOUNT(0064)	589
TERRORISM (9740)	398
1.83% CIGA SURCHARGE	313
1.44% USER / FRAUD / UEBT / SIBT / OSH / LEC	247
TOTAL ESTIMATED PREMIUM	17683
DEPOSIT AMOUNT DUE	17683

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

12432-CO

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
13210 COLUMBINE CT THORTON, CO 80241 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.56**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.25**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
714 BRIAR DATE DR CASTLEROCK, CO 80108 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**333120**	**.56**	**1865**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.25**	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1365 MULBERRY LN HIGHLANDS RANCH, CO 80129 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.56**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.25**	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
21760 MT. ELBERT PLACE PARKER, CO 80138 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	69844	.56	391

CO MANUAL PREMIUM $ 2256

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	25
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	2281
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	$	1962
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1962
4.60% PREMIUM DISCOUNT(0064)		91
TERRORISM (9740)		40
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		40
TOTAL ESTIMATED PREMIUM		1951
DEPOSIT AMOUNT DUE		1951

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-CT

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
10 HOLLY DR E HAMPTON, CT 06424 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**291921**	**1.08**	**3153**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
422 BRIARWOOD DRIVE GUILLFORD, CT 06437 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	90000	1.08	972

CT MANUAL PREMIUM $ 4125

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 46
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	4171
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	3587
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	3587
4.60% PREMIUM DISCOUNT (0064)	165
TERRORISM (9740)	38
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	38
2.75% CT SECOND INJURY FUND SURCHARGE	97
1.60% CT ASSESSMENT FUND	58
TOTAL ESTIMATED PREMIUM	3653
DEPOSIT AMOUNT DUE	3653

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-FL

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1455 FULMAR DR DELRAY BEACH, FL 33444 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**511101**	**1.16**	**5929**
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.49**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
183 NW CROWN JEWEL GLEN LAKE CITY, FL 32055 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**1.16**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.49**	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
601 GREEN ROCK CT APOPKA, FL 32712 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**1.16**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.49**	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
3089 FLORAL WAY E APOPKA, FL 32703 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	1.16	
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.49	
LOCATION 005 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
1503 39TH STREET WEST BRADENTON, FL 34205 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	119346	1.16	1384
LOCATION 006 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
4212 RIVERBANK WAY PORT CHARLOTTE, FL 33980 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	183997	1.16	2134

FL MANUAL PREMIUM $ 9447

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$	132
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	9579
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		8238
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		8238
8.20% PREMIUM DISCOUNT (0063)		676
TERRORISM (9740)		163
TOTAL ESTIMATED PREMIUM		7725
DEPOSIT AMOUNT DUE		7725

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-GA

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1200 BAY POINTE TERRACE ALPHARETTA, GA 30005 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.78**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.32**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**423244**	**.15**	**635**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1187 GOODWIN RD ATLANTA, GA 30324 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	71194	.78	555
SALESPERSONS-OUTSIDE	8742	IF ANY	.32	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.15	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
441 RIDGE BROOK DRIVE DOUGLASVILLE, GA 30134 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS-OUTSIDE	8742	220391	.32	705

GA MANUAL PREMIUM $ 1895

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 21
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	1916
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	1647
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1647
4.60% PREMIUM DISCOUNT(0064)	75
TERRORISM (9740)	143
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	71
TOTAL ESTIMATED PREMIUM	1786
DEPOSIT AMOUNT DUE	1786

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-IL

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1790 W COTTONWOOD TRAIL HOFFMAN ESTATES, IL 60192 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**204399**	**.84**	**1717**
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.27**	
LOCATION 002 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
12031 SMITH DR HUNTLEY, IL 60142 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
INSTRUMENT MFG. NOC	3685	571804	1.18	6747
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.84	
STORE: WHOLESALE-NOC	8018	IF ANY	3.37	
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.27	
CLERICAL OFFICE EMPLOYEES NOC	8810	1661086	.12	1993
LOCATION 003 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
2951 CLYBOURN AVE #205 CHICAGO, IL 60618 SIC CODE: 3841 NAICS: 339112				
X-RAY EQUIPMENT-INSTALLATION, SERVICE OR REPAIR	5191	IF ANY	.84	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
12031 SMITH DRIVE HUNTLEY, IL 60142 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	150738	.12	181
LOCATION 005 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
95329 FLORENCE AVE DOWNERS GROVE, IL 60516 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	212197	.84	1782

IL MANUAL PREMIUM $ 12420

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 174
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$ 12594
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	10830
12.00% SCHEDULE CREDIT (9887)	1300
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	9530
4.60% PREMIUM DISCOUNT(0064)	438
EXPENSE CONSTANT (0900)	280
TERRORISM (9740)	840
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	279
1.01% IL WC COMM OP FUND SURCHARGE	107
TOTAL ESTIMATED PREMIUM	10598
DEPOSIT AMOUNT DUE	10598

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-IN

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
13710 ELMBERRY LN FISHERS, IN 46038 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**238007**	**.45**	**1071**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
2758 E 100 N ANDERSON, IN 46012 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
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EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.45**	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
9850 CROSS CREEK DR NE GREENVILLE, IN 47124 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.45**	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
1530 STONE RIDGE DR GEORGETOWN, IN 47122 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.45	
LOCATION 005 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
6209 GHEENS MILL RD JEFFERSONVILLE, IN 47130 SIC CODE: 3841 NAICS: 339112				
INSTRUMENT MFG. NOC	3685	515881	.32	1651
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.45	
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.19	

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 005 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	1315727	.09	1184

IN MANUAL PREMIUM $ 3906

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	43
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	3949
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		3396
25.00% SCHEDULE CREDIT(9887)		849
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		2547
4.60% PREMIUM DISCOUNT(0064)		117
TERRORISM (9740)		207
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		207
.82% IN SECOND INJURY FUND SURCHARGE		22
TOTAL ESTIMATED PREMIUM		2866
DEPOSIT AMOUNT DUE		2866

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-KS

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
4500 NW 50 CT TOPEKA, KS 66618 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.52**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.23**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
14504 FLOYD ST OVERLAND PARK, KS 66223 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**124854**	**.52**	**649**

TRAVELERS

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HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.23	
LOCATION 003 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
3717 W 121ST ST LEAWOOD, KS 66209 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	432532	.52	2249
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.13	

KS MANUAL PREMIUM $ 2898

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	32
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	2930
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		2520
25.00% SCHEDULE CREDIT (9887)		630
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1890
4.60% PREMIUM DISCOUNT(0064)		86
TERRORISM (9740)		55
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		55
TOTAL ESTIMATED PREMIUM		1914
DEPOSIT AMOUNT DUE		1914

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-KY

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
1421 BARDSTOWN ROAD HODGENVILLE, KY 42748 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**171228**	**.49**	**839**

KY MANUAL PREMIUM $ 839

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	**$ 9**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**848**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**729**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**729**
4.60% PREMIUM DISCOUNT(0064)	**34**
TERRORISM (9740)	**17**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**17**
6.17% KY SPECIAL FUND ASSESSMENT	**45**
TOTAL ESTIMATED PREMIUM	**774**
DEPOSIT AMOUNT DUE	**774**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-LA

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
2706 N RAMPART STREET NEW ORLEANS, LA 70117 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR (COUNTY/TOWN CODE 0252)	**5191**	**107574**	**1.15**	**1237**

LA MANUAL PREMIUM $ 1237

1.40% EMPL. LIAB. INCREASED LIMITS(9812) $	**17**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**1254**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**1078**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**1078**
4.60% PREMIUM DISCOUNT(0064)	**50**
TERRORISM (9740)	**22**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**22**
TOTAL ESTIMATED PREMIUM	**1072**
DEPOSIT AMOUNT DUE	**1072**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-MA

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
NO BUSINESS LOCATION NONE, MA 02101 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**1.04**	
LOCATION 002 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
6 PRINCESS PINE LANE MILFORD, MA 01757 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**82225**	**1.04**	**855**

MA MANUAL PREMIUM $ 855

2.00% EMPL. LIAB. INCREASED LIMITS(9812)	**$**	**16**
DEVIATION PROGRAM CREDIT(9037) 5.00%		**43**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**$**	**828**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		**712**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		**712**
.00% ARAP MODIFICATION PROGRAM (0277)		**NONE**
8.20% PREMIUM DISCOUNT (0063)		**58**
TERRORISM (9740)		**25**
MA WC SPECIAL FUND AND TRUST FUND		**43**
TOTAL ESTIMATED PREMIUM		**722**
DEPOSIT AMOUNT DUE		**722**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-MD

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
638 GATESTONE ST GAITHERSBURG, MD 20878 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**127800**	**.67**	**856**
LOCATION 002 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
409 S LIBERTY ST CENTREVILLE, MD 21617 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	146641	.67	982

MD MANUAL PREMIUM $ 1838

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 20
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	1858
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	1598
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1598
4.60% PREMIUM DISCOUNT(0064)	73
TERRORISM (9740)	82
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	28
TOTAL ESTIMATED PREMIUM	1635
DEPOSIT AMOUNT DUE	1635

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-MI

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 04091680A

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
20981 BRIAR ROSE DR MACOMB, MI 48044 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	**5191**	**IF ANY**	**.61**	
SALESPERSONS-OUTSIDE	**8742**	**IF ANY**	**.17**	
CLERICAL OFFICE EMPLOYEES	**8810**	**IF ANY**	**.08**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
605 MOORLAND GROSSE POINTE WOODS, MI 48236 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	**5191**	**IF ANY**	**.61**	
SALESPERSONS-OUTSIDE	**8742**	**179913**	**.17**	**306**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES	8810	IF ANY	.08	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1510 SHORE CLUB DR ST CLAIR SHORES, MI 48080 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	5191	IF ANY	.61	
SALESPERSONS-OUTSIDE	8742	IF ANY	.17	
CLERICAL OFFICE EMPLOYEES	8810	IF ANY	.08	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
431 EVERGREEN DR HOLLAND, MI 49424 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	5191	440079	.61	2684
SALESPERSONS-OUTSIDE	8742	IF ANY	.17	

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES	8810	IF ANY	.08	
LOCATION 005 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
4721 VOSS AVE HAMILTON, MI 49419 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	5191	IF ANY	.61	
SALESPERSONS-OUTSIDE	8742	IF ANY	.17	
CLERICAL OFFICE EMPLOYEES	8810	IF ANY	.08	
LOCATION 006 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
364 DAUBONY DR BRIGHTON, MI 48114 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, SERVICE OR REPAIR	5191	136152	.61	831
LOCATION 007 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
77 PUTNAM PLACE GROSS POINTE SHORES, MI 48236				
SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 007 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES	8810	59852	.08	48

MI MANUAL PREMIUM $ 3869

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	43
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	3912
EXPERIENCE MODIFICATION: .92 MODIFIED PREMIUM		3599
25.00% SCHEDULE CREDIT(9887)		899
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		2700
4.60% PREMIUM DISCOUNT(0064)		125
TERRORISM (9740)		82
TOTAL ESTIMATED PREMIUM		2657
DEPOSIT AMOUNT DUE		2657

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-MN

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001 **STATE UNEMPLOYMENT IDENTIFIER: 000003498886**				
BC TECHNICAL, INC.				
14405 EDGEWOOD AVE **SAVAGE, MN 55378** **SIC CODE: 3841 NAICS: 339112**				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**111462**	**1.03**	**1148**
LOCATION 002 01				
FEIN 800879403 ENTITY CD 002 **STATE UNEMPLOYMENT IDENTIFIER: 000003498886**				
GENESIS OPCO, LLC				
2130 ERIE DRIVE **NORTHFIELD, MN 55057** **SIC CODE: 3841 NAICS: 339112**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	154936	1.03	1596

MN MANUAL PREMIUM $ 2744

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 31
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	2775
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	2386
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	2386
4.60% PREMIUM DISCOUNT(0064)	110
TERRORISM (9740)	53
6.03% MN SPECIAL COMPENSATION FUND SURCHARGE	144
TOTAL ESTIMATED PREMIUM	2473
DEPOSIT AMOUNT DUE	2473

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

12432-MO

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
7456 STANFORD AVE ST LOUIS, MO 63130 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**173425**	**.70**	**1214**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
605 HERON ST RAYMORE, MO 64083 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.70	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
9840 PARKWAY DR ST LOUIS, MO 63137 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.70	

MO MANUAL PREMIUM $ 1214

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	13
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	1227
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		1055
25.00% SCHEDULE CREDIT(9887)		264
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		791
4.60% PREMIUM DISCOUNT(0064)		36
TERRORISM (9740)		17
6.00% MO SECOND INJURY FUND SURCHARGE		46
1.00% MO ADMINISTRATIVE SURCHARGE		NONE
TOTAL ESTIMATED PREMIUM		818
DEPOSIT AMOUNT DUE		818

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-NC

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
NO BUSINESS LOCATION NONE, NC 27601 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.57**	
LOCATION 002 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
2033 HOLLYHEDGE LANE INDIAN TRAIL, NC 28079 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	110541	.57	630

NC MANUAL PREMIUM $ 630

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	7
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	637
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		548
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		548
4.60% PREMIUM DISCOUNT(0064)		25
TERRORISM (9740)		11
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		11
TOTAL ESTIMATED PREMIUM		545
DEPOSIT AMOUNT DUE		545

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-NE

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
NO BUSINESS LOCATION NONE, NE 68501 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.97**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.36**	

NE MANUAL PREMIUM $ 0

1.10% EMPL. LIAB. INCREASED LIMITS $	**NONE**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**NONE**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**NONE**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**NONE**
4.60% PREMIUM DISCOUNT	**NONE**
TERRORISM (9740)	**NONE**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**NONE**
TOTAL ESTIMATED PREMIUM	**NONE**
DEPOSIT AMOUNT DUE	**NONE**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NJ

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 000587527

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001 **NJ TAX IDENTIFICATION NO.: 870550892000** **BC TECHNICAL, INC.** **356 DRUM POINT RD** **BRICK, NJ 08723** **SIC CODE: 3841 NAICS: 339112**				
OFFICE MACHINE INSTALL OR REPAIR	**5191**	**243928**	**2.09**	**5098**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001 **NJ TAX IDENTIFICATION NO.: 870550892000** **BC TECHNICAL, INC.** **125 RIDGEWOOD WAY** **BURLINGTON, NJ 08016** **SIC CODE: 3841 NAICS: 339112**				
OFFICE MACHINE INSTALL OR REPAIR	**5191**	**IF ANY**	**2.09**	
LOCATION 003 01				
FEIN 611188709 ENTITY CD 003 **NJ TAX IDENTIFICATION NO.: 611188709000** **G&G TECHNOLOGIES, INC** **NO BUSINESS LOCATION** **NONE, NJ 08601** **SIC CODE: 3841 NAICS: 339112**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 01 (CONT'D)				
OFFICE MACHINE INSTALL OR REPAIR	5191	IF ANY	2.09	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002 NJ TAX IDENTIFICATION NO.: 800879403000 GENESIS OPCO, LLC				
132 GLENSIDE TRAIL SPARTA, NJ 07871 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALL OR REPAIR	5191	65887	2.09	1377

NJ MANUAL PREMIUM $ 6475

1.40% EMPL. LIAB. INCREASED LIMITS (6199)	$	90
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	6565
EXPERIENCE MODIFICATION: 1.067 MODIFIED PREMIUM		7005
20.00% SCHEDULE CREDIT (9887)		1401
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		5604
TERRORISM (9740)		93
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		31
6.07% 0935 NJ SECOND INJURY FUND SURCHARGE		425
TOTAL ESTIMATED PREMIUM		6153
TOTAL ESTIMATED COST		6153

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NV

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
8704 MELISSA MEADOWS ST LAS VEGAS, NV 89131 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**80000**	**1.42**	**1136**

NV MANUAL PREMIUM $ 1136

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	**$ 12**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**1148**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**987**
25.00% SCHEDULE CREDIT(9887)	**247**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**740**
4.60% PREMIUM DISCOUNT (0064)	**34**
TERRORISM (9740)	**8**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**8**
TOTAL ESTIMATED PREMIUM	**722**
DEPOSIT AMOUNT DUE	**722**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NY

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1267 CONIFER COVE LN WEBSTER, NY 14580 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	**5191**	**IF ANY**	**2.21**	
SALESPERSONS-OUTSIDE	**8742**	**IF ANY**	**.57**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**107141**	**.26**	**279**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
12 CARLYLE GREEN STATEN ISLAND, NY 10312 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	492298	2.21	10880
SALESPERSONS-OUTSIDE	8742	IF ANY	.57	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
2 DAWNWOOD DR MANORVILLE, NY 11949 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	IF ANY	2.21	
SALESPERSONS-OUTSIDE	8742	IF ANY	.57	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
2829 ROUTE 9G RHINEBECK, NY 12572 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	IF ANY	2.21	
SALESPERSONS-OUTSIDE	8742	131639	.57	750
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	

LOCATION 005 01

FEIN 800879403 ENTITY CD 002

GENESIS OPCO, LLC

85 CHAUCER CIRCLE
BALDWINSVILLE, NY 13027
SIC CODE: 3841 NAICS: 339112

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 005 01 (CONT'D)				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	100631	2.21	2224

NY MANUAL PREMIUM $ 14133

2.80% EMPL. LIAB. INCREASED LIMITS	$	NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	14133
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		12155
0.00% NY CONTR. CLASS PREM. ADJ. PLAN		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		12155
10.50% PREMIUM DISCOUNT (0063)		1276
TERRORISM (9740)		416
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		83
13.20% NY STATE ASSESSMENT(0932)		1670
TOTAL ESTIMATED PREMIUM		13048
DEPOSIT AMOUNT DUE		13048

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-OH

INSURED'S NAME: BC TECHNICAL, INC.

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
9661 MAURER DR OLMSTED TWP, OH 44138 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR INCLUDED IN ** OTHER CHARGES	**5191**	**333079**	**.0240**	**80**
CLERICAL OFFICE EMPLOYEES NOC INCLUDED IN ** OTHER CHARGES	**8810**	**104325**	**.0240**	**25**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
18290 COUNTRY RD MT BLANCHARD, OH 45867 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR INCLUDED IN ** OTHER CHARGES	5191	IF ANY	.0240	
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0240	
CLERICAL OFFICE EMPLOYEES NOC INCLUDED IN ** OTHER CHARGES	8810	IF ANY	.0240	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
8803 KILBOURNE RD SUNBURY, OH 43074 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR INCLUDED IN ** OTHER CHARGES	5191	IF ANY	.0240	
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0240	
CLERICAL OFFICE EMPLOYEES NOC INCLUDED IN ** OTHER CHARGES	8810	IF ANY	.0240	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
FEIN 800879403 ENTITY CD 002 (CONT'D) 49 KNIGHT'S BRIDGE DR W PICKERINGTON, OH 43147 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR INCLUDED IN ** OTHER CHARGES	5191	154527	.0240	37
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0240	
CLERICAL OFFICE EMPLOYEES NOC INCLUDED IN ** OTHER CHARGES	8810	167758	.0240	150

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM $	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	NONE
** OTHER PREMIUM CHARGES	292
TERRORISM (9740)	NONE
TOTAL ESTIMATED PREMIUM	292
DEPOSIT AMOUNT DUE	292

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-OK

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
7410 BLACK COPPER RD STILLWATER, OK 74075 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**133133**	**1.40**	**1864**

OK MANUAL PREMIUM $ 1864

1.40% EMPL. LIAB. INCREASED LIMITS(9812) $	**26**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**1890**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**1625**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**1625**
4.60% PREMIUM DISCOUNT(0064)	**75**
TERRORISM (9740)	**13**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**13**
TOTAL ESTIMATED PREMIUM	**1576**
DEPOSIT AMOUNT DUE	**1576**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-OR

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1014 LILAC ST FOREST GROVE, OR 97116 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**132694**	**1.14**	**1513**

OR MANUAL PREMIUM $ 1513

.40% EMPL. LIAB. INCREASED LIMITS(9812)	**$ 6**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	**1519**
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	**1306**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**1306**
8.20% PREMIUM DISCOUNT (0063)	**107**
TERRORISM (9740)	**13**
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	**13**
6.20% OR TAX AND ASSESSMENT CHARGE	**76**
TOTAL ESTIMATED PREMIUM	**1301**
DEPOSIT AMOUNT DUE	**1301**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

12432-PA

INSURED'S NAME: BC TECHNICAL, INC.

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
139 TROTTERS DR PHOENIXVILLE, PA 19460 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE SERVICE REPAIR	**0952**	**147205**	**.74**	**1089**
LOCATION 002 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
NO BUSINESS LOCATION NONE, PA 17101 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
SALESPERSON-OUTSIDE	0951	IF ANY	.32	

PA MANUAL PREMIUM $ 1089

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 15
.950 MERIT RATING MODIFICATION(9885)	1049
25.00% SCHEDULE CREDIT(9887)	262
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	787
4.60% PREMIUM DISCOUNT(0064)	36
TERRORISM (9740)	44
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	15
1.64% PA EMPL ASSESSMENT (0938)	13
TOTAL ESTIMATED PREMIUM	823
DEPOSIT AMOUNT DUE	823

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE PHOENIX INSURANCE COMPANY

12610-SC

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
3406 HAMLETT CT JOHN'S ISLAND, SC 29455 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.88**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
171 STANLEY COURT LEXINGTON, SC 29073 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**89984**	**.88**	**792**
LOCATION 003 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
3841 FERNIEAF ROAD COLUMBIA, SC 29206 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	48269	.88	425

SC MANUAL PREMIUM $ 1217

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 14
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$ 1231
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	1059
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1059
4.60% PREMIUM DISCOUNT(0064)	49
TERRORISM (9740)	28
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	28
TOTAL ESTIMATED PREMIUM	1066
DEPOSIT AMOUNT DUE	1066

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: FARMINGTON CASUALTY COMPANY

22640-TN

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
230 CHARLIE AVE PINEY FLATS, TN 37686 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.63**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.25**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.12**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
3306 CROSS VALLEY RD KNOXVILLE, TN 37917 SIC CODE: 3841 NAICS: 339112				

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POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	367507	.63	2315
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.25	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.12	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
203 BLUEGRASS CIRCLE LEBANON, TN 37090 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	IF ANY	.63	
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.25	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.12	
LOCATION 004 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
7554 FORREST SHADOW LANE ARLINGTON, TN 38002 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	41737	.63	263

TN MANUAL PREMIUM $ 2578

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$	36
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	2614
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		2248
25.00% SCHEDULE CREDIT(9887)		563
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1685
4.60% PREMIUM DISCOUNT (0064)		78
TERRORISM (9740)		41
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		82
TOTAL ESTIMATED PREMIUM		1730
DEPOSIT AMOUNT DUE		1730

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

15245-TX

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
4800 TREMONT ST #B DALLAS, TX 75246 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	**5191**	**IF ANY**	**.44**	
SALESPERSONS, C M-OUTSIDE	**8742**	**IF ANY**	**.16**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.10**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
12 HAWTHORNE ST NEW WAVERLY, TX 77358 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	**5191**	**491506**	**.44**	**2163**
SALESPERSONS, C M-OUTSIDE	**8742**	**IF ANY**	**.16**	

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.10	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
1509 MICHAEL DR BEDFORD, TX 76022 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	IF ANY	.44	
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	.16	
CLERICAL OFFICE EMPLOYEES NOC	8810	179994	.10	180
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
4009 W HWY 199 SPRINGTOWN, TX 76082 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	IF ANY	.44	
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	.16	

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.10**	
LOCATION 005 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
410 N DOVER AVE LUBBOCK, TX 79416 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	**5191**	**IF ANY**	**.44**	
SALESPERSONS, C M-OUTSIDE	**8742**	**IF ANY**	**.16**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.10**	
LOCATION 006 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
11734 BOURGEOIS FORREST DR HOUSTON, TX 77066 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	**5191**	**IF ANY**	**.44**	
SALESPERSONS, C M-OUTSIDE	**8742**	**IF ANY**	**.16**	

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.10	
LOCATION 007 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
19401 TOMBALL PKWY #932 HOUSTON, TX 77070 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	IF ANY	.44	
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	.16	
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.10	
LOCATION 008 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
14627 WOOD THORN CT HUMBLE, TX 77396 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION OR REPAIR	5191	684370	.44	3011
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.10	
LOCATION 009 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 009 01 (CONT'D)				
FEIN 205224226 ENTITY CD 004 (CONT'D) **4242 5. VINEYARD MEADOW LN.** **KATY, TX 77449** **SIC CODE: 3841 NAICS: 339112**				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 010 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
12130 HAVENMIST DR. **TOMBALL, TX 77375** **SIC CODE: 3841 NAICS: 339112**				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 011 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
2670 MARILEE LN. APT. BLL **HOUSTON, TX 77057** **SIC CODE: 3841 NAICS: 339112**				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 012 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 012 01 (CONT'D)				
FEIN 205224226 ENTITY CD 004 (CONT'D) **6207 BROCKMALL DR.** **KATY, TX 77494** **SIC CODE: 3841 NAICS: 339112**				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 013 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
ALDEN LANDING APT. 7575 **GOSLING RD. 1324** **THE WOODLAND, TX 77382** **SIC CODE: 3841 NAICS: 339112**				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 014 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
9719 SW 1-10 FRONTAGE **SEALY, TX 77474** **SIC CODE: 3841 NAICS: 339112**				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 014 01 (CONT'D)				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 015 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
718 PLACID LAKE LN. MAGNOLIA, TX 77354 SIC CODE: 3841 NAICS: 339112				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	**5191**	**IF ANY**	**.44**	
LOCATION 016 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
2830 BROKEN ARROW MISSOURI CITY, TX 77459 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS, C M-OUTSIDE	**8742**	**IF ANY**	**.16**	
LOCATION 017 01				
FEIN 205224226 ENTITY CD 004				
POLARIS M IMAGING, LLC				
1025 DULLES AVE. APT #628 STAFFORD, TX 77477 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 017 01 (CONT'D)				
X-RAY EQUIPMENT INSTALLATION & REPAIR-PORTABLE	5191	IF ANY	.44	
LOCATION 018 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
2830 BROKEN ARROW MISSOURI CITY, TX 77459 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS, C M-OUTSIDE	8742	72981	.16	117

TX MANUAL PREMIUM $ 5471

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 77
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$ 5548
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	4771
25.00% SCHEDULE CREDIT(9887)	1194
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	3577
9.20% PREMIUM DISCOUNT (0063)	329
TERRORISM (9740)	286
TOTAL ESTIMATED PREMIUM	3534
DEPOSIT AMOUNT DUE	3534

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: THE PHOENIX INSURANCE COMPANY

12610-UT

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001 **STATE UNEMPLOYMENT IDENTIFIER: 1893790000**				
BC TECHNICAL, INC.				
3945 W 8700 S **W JORDAN, UT 84088** **SIC CODE: 3841 NAICS: 339112**				
INSTRUMENT MFG. NOC	**3685**	**IF ANY**	**.57**	
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**.56**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.26**	
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**.11**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001 **STATE UNEMPLOYMENT IDENTIFIER: 1893790000**				
BC TECHNICAL, INC.				
7172 AIRPORT RD **W JORDAN, UT 84084** **SIC CODE: 3841 NAICS: 339112**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
INSTRUMENT MFG. NOC	3685	957372	.57	5457
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	106609	.56	597
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	175596	.26	457
CLERICAL OFFICE EMPLOYEES NOC	8810	1414519	.11	1556

UT MANUAL PREMIUM $ 8067

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	89
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	8156
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM		7014
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		7014
4.60% PREMIUM DISCOUNT(0064)		323
TERRORISM (9740)		265
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		265
TOTAL ESTIMATED PREMIUM		7221
DEPOSIT AMOUNT DUE		7221

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **13579-VA**

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
116 JUSTICE GRICE WILLIAMSBURG, VA 23185 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**137275**	**.93**	**1277**
LOCATION 002 01				
FEIN 611188709 ENTITY CD 003				
G&G TECHNOLOGIES, INC				
7311 LAVA ROCK CIRCLE MANASSAS, VA 20111 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	45826	.93	426

VA MANUAL PREMIUM $ 1703

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 19
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	1722
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	1481
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1481
4.60% PREMIUM DISCOUNT(0064)	68
TERRORISM (9740)	55
TOTAL ESTIMATED PREMIUM	1468
DEPOSIT AMOUNT DUE	1468

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WA

INSURED'S NAME: BC TECHNICAL, INC.

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
753 ONAMAC WAY CAMANO ISLAND, WA 98282 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR INCLUDED IN ** OTHER CHARGES	**5191**	**474813**	**.0220**	**104**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
11 QUIET PLACE BRINNON, WA 98320 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	**8742**	**IF ANY**	**.0220**	
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
3281 MELODY LN SILVERDALE, WA 98383 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0220	
LOCATION 004 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
25104 19TH CT S DES MOINES, WA 98198 SIC CODE: 3841 NAICS: 339112				
SALESPERSONS OR COLLECTORS - OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0220	

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM $	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	NONE
** OTHER PREMIUM CHARGES	104
TERRORISM (9740)	NONE
TOTAL ESTIMATED PREMIUM	104
DEPOSIT AMOUNT DUE	104

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WI

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 911509806

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
5600 EXETER ST GREENDALE, WI 53129 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**293450**	**1.47**	**4314**
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.64**	
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
W333 N6438 RD L OCONOMOWOC, WI 53066 SIC CODE: 3841 NAICS: 339112				

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**1.47**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**255422**	**.64**	**1635**
LOCATION 003 01				
FEIN 870550892 ENTITY CD 001				
BC TECHNICAL, INC.				
9054 32ND AVE KENOSHA, WI 53142 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	**5191**	**IF ANY**	**1.47**	
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**IF ANY**	**.64**	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002				
GENESIS OPCO, LLC				
5083 N 60TH ST MILWAUKEE, WI 53218 SIC CODE: 3841 NAICS: 339112				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 01 (CONT'D)				
OFFICE MACHINE INSTALLATION, INSPECTION, ADJUSTMENT OR REPAIR	5191	210826	1.47	3099

WI MANUAL PREMIUM $ 9048

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	99
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	9147
EXPERIENCE MODIFICATION: .86 MODIFIED PREMIUM	$	7866
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		7866
8.20% PREMIUM DISCOUNT (0063)		646
TERRORISM (9740)		152
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		76
TOTAL ESTIMATED PREMIUM		7448
DEPOSIT AMOUNT DUE		7448

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (B)

POLICY NUMBER: (HJUB-6E20721-A-15)

NJ TAX IDENTIFICATION NO.: 870550892000 **RENEWAL OF (HJUB-6E20721-A-14)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

NCCI CO CODE: 13579

1.

INSURED:

BC TECHNICAL, INC.
7172 S AIRPORT RD
WEST JORDAN UT 84084

PRODUCER:

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

Insured is **A CORPORATION**

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

2. The policy period is from **06-06-15** to **06-06-16** 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:

AL AZ CA CO CT FL GA IL IN KS KY LA MA MD MI MN MO NC NE NJ NV NY OK OR PA SC TN TX UT VA WI

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:	**$**	**1000000**	Each Accident
Bodily Injury by Disease:	**$**	**1000000**	Policy Limit
Bodily Injury by Disease:	**$**	**1000000**	Each Employee

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

AR DC DE HI IA ID ME MS MT NH NM RI SD VT 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.**

See extension of info page.

DATE OF ISSUE: 06-25-15 DS
OFFICE: ST LOUIS 184
PRODUCER: LOCKTON COMPANIES LLC 54274

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 3841 NAICS: 339112

		STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	$	105686
PREMIUM DISCOUNT		5993
OTHER CHARGES & CREDITS		396
0900-12 EXPENSE CONSTANT		280
TERRORISM		3694
CAT (OTHER THAN CERT ACTS OF TERRORISM)		1469
TOTAL ESTIMATED PREMIUM		105136
TAXES AND SURCHARGES		3306
TOTAL ESTIMATED COST		108442

Minimum Premium: $ 1000 **DEPOSIT PREMIUM: $ 11116**

OTHER MINIMUMS ARE INDICATED ON THE APPLICABLE SCHEDULE(S)

DATE OF ISSUE: **06-25-15 DS**
OFFICE: **ST LOUIS 184**
PRODUCER: **LOCKTON COMPANIES LLC 54274**

COUNTERSIGNED-AGENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NJ

INSURED'S NAME: BC TECHNICAL, INC.

RATE BUREAU ID: 000587527

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 870550892 ENTITY CD 001 **NJ TAX IDENTIFICATION NO.: 870550892000** **BC TECHNICAL, INC.** **356 DRUM POINT RD** **BRICK, NJ 08723** **SIC CODE: 3841 NAICS: 339112**				
OFFICE MACHINE INSTALL OR REPAIR	**5191**	**243928**	**2.09**	**5098**
LOCATION 002 01				
FEIN 870550892 ENTITY CD 001 **NJ TAX IDENTIFICATION NO.: 870550892000** **BC TECHNICAL, INC.** **125 RIDGEWOOD WAY** **BURLINGTON, NJ 08016** **SIC CODE: 3841 NAICS: 339112**				
OFFICE MACHINE INSTALL OR REPAIR	**5191**	**IF ANY**	**2.09**	
LOCATION 003 01				
FEIN 611188709 ENTITY CD 003 **NJ TAX IDENTIFICATION NO.: 611188709000** **G&G TECHNOLOGIES, INC** **NO BUSINESS LOCATION** **NONE, NJ 08601** **SIC CODE: 3841 NAICS: 339112**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 01 (CONT'D)				
OFFICE MACHINE INSTALL OR REPAIR	5191	IF ANY	2.09	
LOCATION 004 01				
FEIN 800879403 ENTITY CD 002 NJ TAX IDENTIFICATION NO.: 800879403000 GENESIS OPCO, LLC 132 GLENSIDE TRAIL SPARTA, NJ 07871 SIC CODE: 3841 NAICS: 339112				
OFFICE MACHINE INSTALL OR REPAIR	5191	65887	2.09	1377

NJ MANUAL PREMIUM $ 6475

1.40% EMPL. LIAB. INCREASED LIMITS (6199)	$	90
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	$	6565
EXPERIENCE MODIFICATION: 1.067 MODIFIED PREMIUM		7005
20.00% SCHEDULE CREDIT (9887)		1401
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		5604
TERRORISM (9740)		93
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741		31
6.07% 0935 NJ SECOND INJURY FUND SURCHARGE		425
TOTAL ESTIMATED PREMIUM		6153
TOTAL ESTIMATED COST		6153

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 B - 001	INFORMATION PAGE
WC 00 00 01 B - 001	INFORMATION PAGE 2
WC 00 00 01 B - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 04 03 17 00 - 001	ENDT AGRMNT LIMITING & RESTRICTING INS
WC 99 06 49 00 - 001	EMPLOYERS LIABILITY LIMITS OF LIABILITY
WC 24 04 06 C - 001	MO EMPLOYER PAID MEDICAL ENDT
WC 36 03 06 00 - 001	OREGON LIMITS OF LIABILITY
WC 36 06 02 OO - 001	OREGON CONFIDENTIALITY ENDORSEMENT
WC 99 06 P5 00 - 001	WC AND EMPL LIAB INFO PAGE-OK AMEND ENDT
WC 00 03 03 C - 001	EMPLOYERS LIAB COVERAGE ENDT
WC 00 04 06 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 14 00 - 001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC 00 04 22 B - 001	TERRORISM RISK INS PROG REAUTH ACT ENDT
WC 09 04 03 B - 001	FL TRIPRA ENDORSEMENT
WC 16 03 05 00 - 001	KY PART ONE W.C. INSURANCE ENDORSEMENT
WC 31 06 18 00 - 001	NEW YORK NOTICE OF RIGHT TO APPEAL
WC 32 03 01 C - 001	NORTH CAROLINA AMENDED COVERAGE ENDT
WC 99 03 A1 00 - 001	NOTICE OF CANCELATION
WC 99 03 C3 00 - 001	SPECIAL PROVISIONS ENDT
WC 99 03 D3 A - 001	OH EMPLOYERS LIAB COVERAGE ENDORSEMENT
WC 99 03 F3 00 - 001	CA LIMITS OF LIABILITY ENDT
WC 99 03 99 00 - 001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
WC 99 06 F4 00 - 001	MANAGED CARE PROGRAM ENDORSEMENT
WC 99 06 R3 00 - 001	NOTICE OF CAN TO DESIGN PERSONS OR ORGAN
WC 99 06 11 A - 001	NOTICE OF CANCELLATION
WC 99 06 36 B - 001	WASHINGTON AMENDATORY ENDORSEMENT
WC 00 04 21 D - 001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT
WC 99 01 19 B - 001	TRIPRA DISCLOSURE ENDORSEMENT
WC 99 04 08 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 02 04 01 C - 001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
WC 02 06 01 00 - 001	ARIZONA CANCELATION ENDORSEMENT
WC 04 03 01 B - 001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 04 03 60 A - 001	CA-EMPLOYERS LIAB COV AMENDATORY ENDT
WC 04 04 22 00 - 001	CALIFORNIA SHORT-RATE CANCELATION ENDT
WC 04 06 01 A - 001	CA CANCELATION ENDT

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 05 04 02 00 - 001	COLORADO CLASSIFICATION ENDORSEMENT
WC 06 03 01 00 - 001	CT APPLICATION OF WORKERS COMPENSATION
WC 06 03 03 C - 001	CONNECTICUT WC FUNDS ENDORSEMENT
WC 06 06 01 00 - 001	CT NONRENEWAL ENDORSEMENT
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 04 07 00 - 001	FL NON-COOPERATION WITH PREM AUDIT ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.
WC 10 04 02 00 - 001	GA NON-COOPERATION WITH PREM AUDIT ENDT
WC 10 06 01 B - 001	GA CANCELLATION, NONREN, AND CHANGE ENDT
WC 12 06 01 E - 001	IL AMENDATORY ENDT
WC 15 04 01 A - 001	KANSAS FINAL PREMIUM ENDORSEMENT
WC 15 06 01 A - 001	KANSAS CANCELATION AND NONRENEWAL ENDT.
WC 16 06 01 00 - 001	KY CANCELATION AND NONRENEWAL ENDT.
WC 16 06 02 00 - 001	KENTUCKY NOTICE OF APPEAL RIGHTS ENDT
WC 17 06 01 E - 001	LOUISIANA AMENDATORY ENDORSEMENT
WC 17 06 02 A - 001	LA COST CONTAINMENT ACT ENDORSEMENT
WC 19 06 01 E - 001	MD CANCELLATION AND NONRENEWAL ENDT
WC 20 03 01 00 - 001	MA LIMITS OF LIABILITY ENDORSEMENT
WC 20 03 02 A - 001	MASSACHUSETTS - ASSESMENT CHARGE
WC 20 03 03 D - 001	MA NOTICE TO POLICYHOLDER ENDORSEMENT
WC 20 04 01 00 - 001	MASS PENDING PREM CHANGE ENDT
WC 20 04 05 00 - 001	MASSACHUSETTS PREMIUM DUE DATE ENDT
WC 20 06 01 A - 001	MA CANCELLATION ENDORSEMENT
WC 21 03 03 A - 001	MICHIGAN NOTICE TO POLICYHOLDERS
WC 21 03 04 00 - 001	MICHIGAN LAW ENDORSEMENT
WC 22 00 00 A - 001	MN AMENDATORY ENDT
WC 22 03 01 00 - 001	MN COMPLIANCE WITH APPLICABLE TRADE LAW
WC 22 06 01 D - 001	MINNESOTA CANC AND NON RENEWAL ENDT
WC 24 03 02 00 - 001	MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT
WC 24 06 01 B - 001	MO CANCELATION AND NON-RENEWAL ENDT.
WC 24 06 02 B - 001	MO PROPERTY & CASUALTY GUARANTY ASSOC.
WC 24 06 04 A - 001	MISSOURI AMENDATORY ENDORSEMENT
WC 26 06 01 C - 001	NE CANCELATION ENDT
WC 27 06 01 C - 001	NV CANCELLATION AND NON RENEWAL ENDT
WC 29 03 06 B - 001	NJ PART TWO EMPLOYERS LIABILITY ENDT.
WC 31 03 08 00 - 001	NEW YORK LIMIT OF LIABILITY ENDORSEMENT
WC 31 03 19 G - 001	NY CONST CLASS PREM ADJUST PROG
WC 35 03 03 00 - 001	OK EMP LIAB INTENTIONAL TORT EXCL ENDT
WC 35 06 01 F - 001	OK CAN, NONRENEWAL AND CHANGE ENDT
WC 35 06 03 00 - 001	OK FRAUD WARNING ENDT

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 36 03 01 00 - 001	**OREGON UNSAFE EQUIPMENT EXCLUSION END.**
WC 36 04 06 00 - 001	**OREGON PREMIUM DUE DATE**
WC 36 06 01 E - 001	**OR CANCELLATION ENDORSEMENT**
WC 37 04 05 00 - 001	**PA MERIT RATING PLAN ENDT**
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**
WC 41 04 02 00 - 001	**TN PENDING LOSS COST & ASSIGN RISK RATE**
WC 42 03 01 G - 001	**TEXAS AMENDATORY ENDORSEMENT**
WC 42 04 07 00 - 001	**TX AUDIT PREMIUM & RETRO PREM ENDT**
WC 43 06 01 00 - 001	**UT WORKPLACE SAFETY PROG ENDT**
WC 43 06 02 00 - 001	**UTAH CANCELLATION ENDORSEMENT**
WC 45 06 02 00 - 001	**VA AMENDATORY ENDT**
WC 48 06 01 C - 001	**WISCONSIN LAW ENDORSEMENT**
WC 48 06 06 B - 001	**WISCONSIN CANCELLATION AND NON RENEWAL**
WC 99 06 Q5 00 - 001	**OK STATUTORY PROVISIONS ENDORSEMENT**
WC 99 06 46 00 - 001	**ILLINOIS AMENDATORY ENDORSEMENT**
WC 17 03 03 00 - 001	**LOUISIANA DUTY TO DEFEND**
WC 29 04 11 B - 001	**NEW JERSEY PREM DISC ENDT SCHEDULE Y**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 49 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

EMPLOYERS LIABILITY LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New Jersey is shown in Item 3.A. of the Information Page.

1. The applicable limits of liability stated in Item 3.B.of the New Jersey Information Page WC 00 00 01 (B) and the limits of liability stated in the Countrywide Information Page WC 00 00 01 (A) of this policy refer to ONE AND THE SAME set of limits for Bodily Injury by Accident, Each Accident; Bodily Injury by Disease, Policy Limit; and Bodily Injury by Disease, Each Employee.

2. All other references to Part Two (Employers Liability Insurance) limits of liability within the policy remain unchanged.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 24 04 06 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT

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

As a Missouri employer, you have the right, as provided by Section 287.957 of the Revised Statutes of Missouri, to have medical-only claims that do not exceed $1,000 excluded from your experience modification calculation. This will only be allowed when you pay all of the employee's medical costs, there is no lost time from the employment, other than the first three days or less of disability and no claim is filed. You still must report all injuries, regardless of the dollar amount, to the Division of Workers' Compensation and to us.

However, it should be noted that if, at any time, the medical expenses that are paid "out-of-pocket" due to a particular injury should ever exceed $1,000 in the aggregate, and/or the employee misses more than three days from work due to the injury, then this injury must be reported to us as a claim. We will pay the full amount of the claim, which includes any reimbursements due to you for past medical expenses incurred by you for this particular claim. As a result, the total amount of losses incurred by us due to this claim will be included in your experience modification calculation.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 03 06 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OREGON LIMITS OF LIABILITY 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 limits of our liability under Part Two of the policy are:

Bodily Injury by Accident	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each accident
Bodily Injury by Disease	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, policy limit
Bodily Injury by Disease	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each employee

This change applies to the insurance this policy provides for Oregon operations only.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 02 (OO)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OREGON CONFIDENTIALITY ENDORSEMENT

We may furnish you with certain documentation that includes confidential information. As used in this endorsement, "confidential information" means any and all medical and vocational claim records and information about an injured worker. We make this information available to you for the sole purpose of assisting us to manage, defend, or adjust claims.

1. You agree to hold all information provided by us in trust and confidence.

2. You and your employees must not disclose confidential information about an injured worker to anyone except us unless required to do so by law or with written consent of the injured worker. You will take steps necessary to protect the confidentiality of information about injured workers, including obtaining specific contractual promises from your employees and agents not to disclose any confidential information except as provided in this endorsement. You must not use confidential information for purposes other than those necessary to directly further the purposes of this endorsement.

3. You must not use confidential information in such a manner that is likely to allow other persons to know the name or identity of an injured worker, or allow other persons to know any other particulars of a worker's injury claim, except for those matters over which you as an employer have the ability and the right to direct and control. In no case can you use confidential information either singly or in concert to discriminate unlawfully against any injured worker.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 P5 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY INFORMATION PAGE – OKLAHOMA AMENDATORY ENDORSEMENT

This form amends item 2 of the Workers Compensation and Employers Liability Policy Information Page to clarify that policy period is effective 12:01 A.M. standard time at the insured's mailing address.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 03 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

WA

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 _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 06 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 $5,000	Next $95,000	Next $400,000	Balance

2. AVERAGE PERCENTAGE DISCOUNT: See Information Page Schedule(s)

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:

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 14 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 22 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 States Government 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 exceed $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 Remuneration

SEE INFORMATION PAGE SCHEDULE FOR PREMIUM CHARGE

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 03 05 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE ENDORSEMENT

This endorsement modifies the insurance policy to which it is attached and applies to the insurance provided by this policy because Kentucky is shown in Item 3.A. of the Information Page.

F. 3. of Part One, Workers Compensation Insurance of the policy is replaced by the following:

F. Payments You Must Make

3. you fail to comply with a health or safety law or regulation; provided that, however, we are responsible for payment of any amounts in excess of the benefits regularly provided under the workers compensation law of this state if an accident is caused in any degree by the intentional failure of the employer to comply with any specific statute or lawful administrative regulation made thereunder, communicated to the employer and relative to the installation or maintenance of safety appliances or methods as provided in KRS 342.165(1); or

Except for any payments for which we are responsible as provided in Section F.3. above, 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.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 31 06 18 (00)

POLICY NUMBER: (HJUB-6E20721-A-15)

NEW YORK WORKERS COMPENSATION POLICYHOLDER NOTICE OF RIGHT TO APPEAL

Policyholder Disputes

Policyholders are entitled to inquire, challenge and dispute issues relating to classification, ownership, premium auditing, and/or other New York Compensation Insurance Rating Board (NYCIRB) rulings or decisions pertaining to this policy. Please refer to the Employer's Appeal Process noted below.

Inquiries may also be directed to the New York State Department of Financial Services (DFS) at:

http://www.dfs.ny.gov/about/contactus.htm#consumer

or by calling the Consumer Hotline at 800- 342 – 3736 (Monday through Friday, 8:30 AM to 4:30 PM).

Policyholder Right to Appeal

An insured, or its representative, (hereafter referred to as "insured"), may appeal the application of a rule or procedure contained in the NY Workers Compensation & Employers Liability Manual. Rules or procedures are defined as those determinations, either by a carrier or the Rating Board, which define the variables which makeup the policy conditions. Examples include: classification codes, ownership information, premium audits, and any other determination which may affect the policy.

To be considered for review, a written request explaining the reason(s) for the appeal must be submitted to the Rating Board. Upon receipt of the request for review, the following actions will be taken:

1. A staff member will review the request and respond to the insured within sixty (60) days, in writing, acknowledging receipt of the request, granting the insured its request or sustaining its original ruling.

2. The insured, if not satisfied with the outcome in 1. above, may then request, in writing, a conference with members of the Rating Board staff. The request must state the nature of the complaint and contain any supporting documents. The appropriate Department Vice President or his or her designated representative, if appropriate, will preside at the conference.

3. If the dispute is not resolved at the conference, the insured may then appeal to the Underwriting Committee of the Rating Board for a hearing to consider the staff ruling. This appeal must be in writing and must specify the reason(s) for the appeal and the nature of the complaint.

   Following, receipt of the appeal, the insured will be notified regarding the time and place for the hearing. The appeal will be heard at the next Underwriting Committee meeting for which appropriate time can be given for this matter. Subsequent to the hearing, the insured will be advised, in writing, of the Underwriting Committee decision regarding its complaint.

4. If the Underwriting Committee ruling is not satisfactory to the insured, the insured may then request a hearing at the New York State Department of Financial Services to consider the decision of the Rating Board's Underwriting Committee.

5. The New York State Department of Financial Services decision may be appealed to a higher court, by either the insured or the Rating Board

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 32 03 01 (C)

POLICY NUMBER: (HJUB-6E20721-A-15)

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

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

The **Cancellation** Condition of the policy is replaced by this Condition:

D. Cancellation and Nonrenewal

1. You may cancel this policy. If you 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) If this policy has been in effect for fewer than 60 days and is not a renewal policy, we may cancel this policy for any reason by giving you at least 30 days prior written notice of cancellation and the reasons for cancellation by registered or certified mail, return receipt requested.

(b) If this policy has been in effect for at least 60 days or is a renewal policy, we may not cancel this policy without your prior written consent, except for any one of the following reasons:

(1) Nonpayment of premium in accordance with the policy terms.

(2) An act or omission by you or your representative that constitutes material misrepresentation or nondisclosure of a material fact in obtaining the policy, continuing the policy, or presenting a claim under the policy.

(3) Increased hazard or material change in the risk assumed that could not have been reasonably contemplated by you and us at the time of assumption of the risk.

(4) Substantial breach of contractual duties, conditions, or warranties that materially affects the insurability of the risk.

(5) A fraudulent act against us by you or your representative that materially affects the insurability of the risk.

(6) Willful failure by you or your representative to institute reasonable loss control measures that materially affect the insurability of the risk after written notice by us.

(7) Loss of facultative reinsurance or loss of or substantial changes in applicable reinsurance as provided in G.S. 58-41-30.

(8) Your conviction of a crime arising out of acts that materially affect the insurability of the risk.

(9) A determination by the Commissioner that the continuation of this policy would place us in violation of the laws of North Carolina.

(10) You fail to meet the requirements contained in our corporate charter, articles of incorporation, or bylaws, when we are a company organized for the sole purpose of providing members of an organization with insurance coverage in North Carolina.

(c) If we cancel for any of the reasons listed in paragraph (b), we must provide you with at least 15 days prior written notice of cancellation stating the precise reason for cancellation. We may provide this notice by registered or certified mail, return receipt requested, to you and any other person designated in the policy to receive notice of cancellation at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Whenever notice of cancellation is given by registered or certified mail, cancellation will not be effective unless and until that method is employed and

completed. Notice of cancellation may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send notice as provided in this paragraph to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

(d) Cancellation for nonpayment of premium is not effective if the amount due is paid before the effective date stated in the notice of cancellation.

3. We may refuse to renew this policy:

(a) If this policy is for a term of one year or less, we must provide you with notice of nonrenewal at least 45 days prior to the expiration date of the policy.

(b) If this policy is for a term of more than one year or for an indefinite term, then to nonrenew the policy at the policy anniversary date we must provide you with notice of nonrenewal at least 45 days prior to the anniversary date of the policy.

(c) The notice of nonrenewal must state the precise reason for nonrenewal. Failure to send this notice, as provided in paragraphs 3 and 5, to any other person designated in the policy to receive this notice invalidates the nonrenewal only as to that other person's interest.

(d) Any nonrenewal attempted or made that is not in compliance with paragraphs (a), (b) and (c) is not effective. Paragraphs (a), (b) and (c) do not apply if you have obtained insurance elsewhere, have accepted replacement coverage, or have requested or agreed to nonrenewal.

4. Whenever we lower coverage limits, raise deductibles, or raise premium rates for reasons within our exclusive control and other than at your request, we will mail you written notice of the change at least 30 days in advance of the effective date of the change. As used in this paragraph, the phrase, "reasons within our exclusive control" does not mean experience modification changes, exposure changes, or loss cost rate changes.

5. We must provide the notice required by paragraphs 3 and 4 by mail to you and any other person designated in the policy to receive this notice at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Mailing copies of the notice by regular first-class mail satisfies the notice requirements of paragraphs 3, 4 and 5.

6. We will also send copies of the notice required by this endorsement to the agent or broker of record, though failure to send copies of the notice to the agent or broker of record will not invalidate a cancellation or nonrenewal. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this paragraph. Notice of nonrenewal may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure.

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 _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 A1 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF CANCELATION

Colorado Revised Statute 8-44-110 requires all insurance carriers to give a 30 day notice of cancelation, except in the case of: Fraud; Material Misrepresentation; Nonpayment of Premium; Other reasons approved by the Commissioner of Insurance.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 C3 (00) – 001

POLICY NUMBER: **(HJUB-6E20721-A-15)**

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 00 03 03 (C)-001	**CW EMPLOYERS LIABILITY COVERAGE ENDORSEMENT**
APPLIES TO STATE(S):	**AL AZ CO CT GA IL IN KS KY LA MD MN MO NE NV NY NC OK OR PA SC TN TX UT VA WI**
WC 00 04 06 (00)-001	**PREMIUM DISCOUNT ENDORSEMENT**
APPLIES TO STATE(S):	**AL CT GA KS KY MO NE NV NJ NC SC TN TX VA**
WC 00 04 14 (00)-001	**NOTIFICATION OF CHANGE IN OWNERSHIP ENDT**
APPLIES TO STATE(S):	**AL AZ CO CT FL GA IL IN KS KY LA MD MA MN MO NE NV NY NC OK OR SC TN UT VA WI**
WC 00 04 19 (00)-001	**MULTI-STATE PREMIUM DUE DATE ENDORSEMENT**
APPLIES TO STATE(S):	**AL CO CT FL GA IL IN KS KY LA MD MN MO NE NV NJ NY NC OK PA SC TN UT VA WI**
WC 00 04 21 (D)-001	**CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORIS**
APPLIES TO STATE(S):	**AL AZ CA CO CT GA IL IN KS KY LA MD NE NV NJ NY NC OK OR PA SC TN UT WI**
WC 00 04 22 (B)-001	**TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION A**
APPLIES TO STATE(S):	**AL AZ CA CO CT GA IL IN KS KY LA MD MA MI MN MO NE NV NJ NY NC OK OR PA SC TN TX UT VA WI**
WC 02 04 01 (C)-001	**ARIZONA ALCOHOL AND DRUG-FREE WORKPLACE PREM**
APPLIES TO STATE(S):	**AZ**
WC 02 06 01 (00)-001	**ARIZONA CANCELATION ENDORSEMENT**
APPLIES TO STATE(S):	**AZ**
WC 04 03 01 (B)-001	**CA POLICY AMENDATORY ENDORSEMENT-CALIFORNIA**
APPLIES TO STATE(S):	**CA**
WC 04 03 17 (00)-001	**CA ENDORSEMENT AGREEMENT LIMITING AND RESTRICG**
APPLIES TO STATE(S):	**CA**
WC 04 03 60 (A)-001	**CA EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDT**
APPLIES TO STATE(S):	**CA**
WC 04 04 22 (00)-001	**CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT**
APPLIES TO STATE(S):	**CA**
WC 04 06 01 (A)-001	**CA CANCELATION ENDT**

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 NUMBER: **(HJUB-6E20721-A-15)**

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S): CA
WC 05 04 02 (00)-001 COLORADO CLASSIFICATION ENDORSEMENT
APPLIES TO STATE(S): CO
WC 06 03 01 (00)-001 CT APPLICATION OF WORKERS COMPENSATION
APPLIES TO STATE(S): CT
WC 06 03 03 (C)-001 CONNECTICUT WORKERS COMPENSATION FUNDS
APPLIES TO STATE(S): CT
WC 06 06 01 (00)-001 CT NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): CT
WC 09 03 03 (00)-001 FL EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
APPLIES TO STATE(S): FL
WC 09 04 03 (B)-001 FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORI
APPLIES TO STATE(S): FL
WC 09 04 07 (00)-001 FLORIDA NON-COOPERATION WITH PREMIUM AUDIT
APPLIES TO STATE(S): FL
WC 09 06 06 (00)-001 FL EMPLOYMENT AND WAGE INFORMATION REL. ENDT.
APPLIES TO STATE(S): FL
WC 10 04 02 (00)-001 GA NON-COOPERATION WITH PREMIUM AUDIT ENDT
APPLIES TO STATE(S): GA
WC 10 06 01 (B)-001 GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDOR
APPLIES TO STATE(S): GA
WC 12 06 01 (E)-001 ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): IL
WC 15 04 01 (A)-001 KANSAS FINAL PREMIUM ENDORSEMENT
APPLIES TO STATE(S): KS
WC 15 06 01 (A)-001 KANSAS CANCELATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): KS
WC 16 03 05 (00)-001 KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE E
APPLIES TO STATE(S): KY
WC 16 06 01 (00)-001 KENTUCKY CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): KY
WC 16 06 02 (00)-001 KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT
APPLIES TO STATE(S): KY
WC 17 03 03 (00)-001 LA DUTY TO DEFEND ENDORSEMENT
APPLIES TO STATE(S): LA
WC 17 06 01 (E)-001 LOUISIANA AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): LA
WC 17 06 02 (A)-001 LA COST CONTAINMENT ACT ENDORSEMENT
APPLIES TO STATE(S): LA
WC 19 06 01 (E)-001 MARYLAND CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): MD

POLICY NUMBER: **(HJUB-6E20721-A-15)**

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 20 03 01 (00)-001 MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 03 02 (A)-001 MASSACHUSETTS ASSESSMENT CHARGE
APPLIES TO STATE(S): MA
WC 20 03 03 (D)-001 MASSACHUSETTS NOTICE TO POLICYHOLDER ENDT
APPLIES TO STATE(S): MA
WC 20 04 01 (00)-001 MASS PENDING PREM CHANGE ENDT
APPLIES TO STATE(S): MA
WC 20 04 05 (00)-001 MA PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 06 01 (A)-001 MASSACHUSETTS CANCELLATION ENDT
APPLIES TO STATE(S): MA
WC 21 03 03 (A)-001 MI NOTICE TO POLICYHOLDER ENDORSEMENT
APPLIES TO STATE(S): MI
WC 21 03 04 (00)-001 MICHIGAN LAW ENDORSEMENT
APPLIES TO STATE(S): MI
WC 22 00 00 (A)-001 MINNESOTA AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MN
WC 22 03 01 (00)-001 MN COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS
APPLIES TO STATE(S): MN
WC 22 06 01 (D)-001 MINNESOTA CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): MN
WC 24 03 02 (00)-001 MO NOTIFICATION OF ADDL MESOTHELIOMA BENEFITS END
APPLIES TO STATE(S): MO
WC 24 04 06 (C)-001 MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT
APPLIES TO STATE(S): MO
WC 24 06 01 (B)-001 MO CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): MO
WC 24 06 02 (B)-001 MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOC.
APPLIES TO STATE(S): MO
WC 24 06 04 (A)-001 MISSOURI AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MO
WC 26 06 01 (C)-001 NE CANCELATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): NE
WC 27 06 01 (C)-001 NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): NV
WC 29 03 06 (B)-001 NEW JERSEY PART TWO EMPRS LIABILITY ENDT
APPLIES TO STATE(S): NJ
WC 29 04 11 (B)-001 NEW JERSEY PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S): NJ
WC 31 03 08 (00)-001 NEW YORK LIMIT OF LIABILITY ENDORSEMENT

POLICY NUMBER: (HJUB-6E20721-A-15)

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S):	NY
WC 31 03 19 (G)-001	NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM
APPLIES TO STATE(S):	NY
WC 31 06 18 (00)-001	NEW YORK WORKERS COMPENSATION POICYHOLDER NOTICE
APPLIES TO STATE(S):	NY
WC 32 03 01 (C)-001	NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT
APPLIES TO STATE(S):	NC
WC 35 03 03 (00)-001	OK EMPLOYERS LIABILITY INTENTIONAL TORT
APPLIES TO STATE(S):	OK
WC 35 06 01 (F)-001	OKLAHOMA CANCELLATION, NONRENL AND CHG ENDT
APPLIES TO STATE(S):	OK
WC 35 06 03 (00)-001	OK FRAUD WARNING ENDT
APPLIES TO STATE(S):	OK
WC 36 03 01 (00)-001	OREGON UNSAFE EQUIPMENT EXCLUSION ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 36 03 06 (00)-001	OREGON LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 36 04 06 (00)-001	OREGON PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 36 06 01 (E)-001	OREGON CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 36 06 02 (OO)-001	OR OREGON CONFIDENTIALITY ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 37 04 05 (00)-001	PENNSYLVANIA MERIT RATING PLAN ENDT
APPLIES TO STATE(S):	PA
WC 37 06 01 (00)-001	SPECIAL PA ENDORSEMENT -- INSPECTION OF MANUALS
APPLIES TO STATE(S):	PA
WC 37 06 02 (00)-001	NOTICE INS CONSULTATION SERVICE EXEMPTION ACT
APPLIES TO STATE(S):	PA
WC 37 06 03 (A)-001	PENNSYLVANIA ACT 86-1986 ENDORSEMENT
APPLIES TO STATE(S):	PA
WC 37 06 04 (00)-001	PA EMPLOYER ASSESSMENT ENDORSEMENT
APPLIES TO STATE(S):	PA
WC 41 04 02 (00)-001	TN PENDING LOSS COST AND ASSIGNED RISK RATE ENDT
APPLIES TO STATE(S):	TN
WC 42 03 01 (G)-001	TX AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	TX
WC 42 04 07 (00)-001	TX AUDIT PREMIUM AND RETROSPECTIVE PREMIUM
APPLIES TO STATE(S):	TX
WC 43 06 01 (00)-001	UT WORKPLACE SAFETY PROG ENDT
APPLIES TO STATE(S):	UT

POLICY NUMBER: (HJUB-6E20721-A-15)

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 43 06 02 (00)-001	UT CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):	UT
WC 45 06 02 (00)-001	VA AMENDATORY ENDT
APPLIES TO STATE(S):	VA
WC 48 06 01 (C)-001	WI LAW ENDORSEMENT
APPLIES TO STATE(S):	WI
WC 48 06 06 (B)-001	WI CANCELLATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S):	WI
WC 99 01 19 (B)-001	TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION A
APPLIES TO STATE(S):	
WC 99 03 A1 (00)-001	CANC NOTICE ENDT-COLORADO
APPLIES TO STATE(S):	CO
WC 99 03 C3 (00)-001	CA SPECIAL PROVISIONS ENDORSEMENT
APPLIES TO STATE(S):	AL AZ CA CO CT FL GA IL IN KS KY LA MD MA MI MN MO NE NV NJ NY NC OK OR PA SC TN TX UT VA WI
WC 99 03 D3 (A)-001	OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
APPLIES TO STATE(S):	
WC 99 03 F3 (00)-001	CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S):	CA
WC 99 03 99 (00)-001	CA NOTICE OF NON-RENEWAL
APPLIES TO STATE(S):	CA
WC 99 04 08 (00)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	AL AZ CA CO CT FL GA IL IN KS KY LA MD MA MI MN MO NE NV NY NC OK OR PA SC UT VA WI
WC 99 06 F4 (00)-001	MANAGED CARE PROGRAM ENDORSEMENT
APPLIES TO STATE(S):	CA CT KY MA OK OR
WC 99 06 P5 (00)-001	OK WORKERS COMPENSATION AND EMPLOYERS LIAB.
APPLIES TO STATE(S):	OK
WC 99 06 Q5 (00)-001	OKLAHOMA STATUTORY PROVISIONS ENDORSEMENT
APPLIES TO STATE(S):	OK
WC 99 06 R3 (00)-001	NOTICE OF CANC TO DESIGNATED PERSONS OR ORG
APPLIES TO STATE(S):	AL CA CO CT GA IL IN KS KY LA MD MA MI MN MO NE NV NY OK OR PA SC TN UT VA
WC 99 06 11 (A)-001	NOTICE OF CANCELLATION
APPLIES TO STATE(S):	NC
WC 99 06 36 (B)-001	WASHINGTON AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	
WC 99 06 46 (00)-001	ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	IL
WC 99 06 49 (00)-001	NJ EMPLOYERS LIABILITY LIMITS OF LIABILITY ENDORSE
APPLIES TO STATE(S):	NJ

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 D3 (A) – 001

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 5. is removed and replaced with the following:

C. Exclusions

This insurance does not cover:

5. bodily injury directly intended by the insured;

Part Two (Employers Liability Insurance), C. Exclusions is changed by adding these exclusions:

14. bodily injury to an employee when you are deprived by common law defense 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 the law.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 99 03 F3 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CALIFORNIA LIMITS OF LIABILITY 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 limits of our liability under Part Two of the policy are:

Bodily Injury by Accident	$1,000,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each accident
Bodily Injury by Disease	$1,000,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, policy limit
Bodily Injury by Disease	$1,000,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each employee

This change applies to the insurance this policy provides for California operations only.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 03 99 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CALIFORNIA WORKERS' COMPENSATION
NOTICE OF NON-RENEWAL

Section 11664 of the California Insurance Code which becomes operative November 30, 1994 requires us in most instances to provide you with a notice of non-renewal. Except as specified in paragraphs 1 through 6 below, if we elect to non-renew your policy, we are required to deliver or mail to you a written notice stating the reason or reasons for the non-renewal 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 non-renewal 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 at least 30 days, but not more than 120 days, prior to the end of the policy period to renew the policy at a changed premium rate.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 F4(00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MANAGED CARE PROGRAM ENDORSEMENT

This endorsement applies only to the insurance provided by this policy for the states listed in the schedule below.

This endorsement provides for the payment of benefits under the Workers' Compensation law for medical services and health care to injured workers for compensable injuries and diseases by means of a MANAGED CARE PROGRAM which meets the requirements established by the state. Managed Care Programs are approved on a county by county basis in most states. As an employer you have a responsibility to your employees to comply with the requirements of each county as applicable.

SCHEDULE

Item #1 (STATES)

CA

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 R3 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF CANCELLATION TO DESIGNATED PERSONS OR ORGANIZATIONS

The following is added to **PART SIX – CONDITIONS**:

Notice Of Cancellation To Designated Persons Or Organizations

If we cancel this policy for any reason other than non-payment of premium by you, we will provide notice of such cancellation to each person or organization designated in the Schedule below. We will mail or deliver such notice to each person or organization at its listed address at least the number of days shown for that person or organization before the cancellation is to take effect.

You are responsible for providing us with the information necessary to accurately complete the Schedule below. If we cannot mail or deliver a notice of cancellation to a designated person or organization because the name or address of such designated person or organization provided to us is not accurate or complete, we have no responsibility to mail, deliver or otherwise notify such designated person or organization of the cancellation.

SCHEDULE

Name and Address of Designated Persons or Organizations:	**Number of Days Notice**
MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT **ATTN: RISK MANAGEMENT** **2411 W. 14TH STREET** **TEMPE, AZ 85281**	**30**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 R3 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Name and Address of Designated Persons or Organizations:	**Number of Days Notice**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 R3 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Name and Address of Designated Persons or Organizations:

Number of Days Notice

All other terms and conditions of this policy remain unchanged.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 11 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF CANCELLATION

Except for non-payment of premium by you, we agree that no cancellation or limitation of this policy shall become effective until the number of day's written notice specified in item 2 of the Schedule has been mailed to you and to the person or organization designated in item 1 of the Schedule at the address indicated.

SCHEDULE

1. Name: **CBRE**

Address: **1601 E. 19TH AVENUE**
SUITE 3025
DENVER, CO 80218

2. Number of Days Written Notice: **30** Additional 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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: (HJUB-6E20721-A-15)

WASHINGTON AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Washington is shown in the Schedule of the Employers Liability Coverage Endorsement that is part of this policy.

1. The following replaces the last sentence of Paragraph **D.**, **We Will Defend**, of **PART TWO – EMPLOYERS LIABILITY INSURANCE**:

Our right and duty to defend ends when we have exhausted the applicable limit of liability in the payment of judgments or settlements, or we mutually agree otherwise.

2. The following replaces Paragraph **E.**, **Final Premium**, of **PART FIVE – PREMIUM**:

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 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 on the policy.

If this policy is canceled, final premium will be determined in the following way:

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 and you are not retiring from business, 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 procedures. Final premium will not be less than the minimum premium.

3. If you cancel and you are retiring from business, final premium will be calculated pro rata based on the time this policy was in force and will not be less than the pro rata share of the minimum premium.

3. The following replaces Paragraph **D.**, **Cancelation**, of **PART SIX – CONDITIONS**:

D. Cancelation

1. You may cancel this policy by providing us with advance notice using one of the following methods:

a. Written notice of cancellation to us or our agent by mail, fax or email;

b. Surrender of the policy to us or our agent; or

c. Verbal notice to us or our agent.

If we or our agent receives such notice, we will cancel this policy, or any binder issued as evidence of coverage, effective on the later of:

a. The date notice was received; or

b. The date of cancelation that you have requested.

If you provide verbal notice of cancelation to us, we may require you to provide written confirmation of cancelation, but we may not impose a waiting period for cancelation by requiring such written confirmation.

2. We may cancel this policy by delivering or mailing to you, and to each pledgee or other person shown in this policy to have interest in any loss which may occur under this policy, written notice of cancelation at least:

a. Ten days before the effective date of cancelation, if we cancel for nonpayment of premium; or

b. Forty-five days before the effective date of cancelation, if we cancel for any other reason.

3. Notice of cancelation will state the actual reason for cancelation and the effective date of cancelation.

4. Mailing of the notice to you at your mailing address last known to us will be sufficient to prove notice.

4. The following is added to **PART SIX – CONDITIONS**:

Nonrenewal

We will renew this policy unless:

1. We deliver or mail to you, at your address last known to us, written notice stating the actual reason for nonrenewal, at least 45 days before the expiration date of the policy;

2. At least 20 days before the expiration date of this policy, we have communicated to you or your agent in writing our willingness to renew this policy and have included in that writing a statement of the amount of the premium you are required to pay to renew the policy, and you have failed to discharge when due your obligation in connection with the payment of such premium; or

3. You have procured equivalent coverage before the expiration date of this policy.

All other terms and conditions of this policy remain unchanged.

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 N**o.** EndorsementNo.

Insured Premium$

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 21 (D)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

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.

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 _____	

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 04 08 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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:

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 19 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.**

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 04 01 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ARIZONA ALCOHOL – AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

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

This endorsement provides notice that premium for your policy may be affected by the Arizona Alcohol-and Drug-Free Workplace Premium Credit Program.

You may qualify for a 5% premium credit if you have established and maintain a qualifying alcohol-and drug-free workplace program in accordance with Title 23, Chapter 2, Article 14 of Arizona Statutes.

We will determine your eligibility for this premium credit after total premium has been paid for the policy period and may be revised at the time your final premium audit is processed.

The determination that you have a qualifying program must be made each year that you receive the premium credit. To implement a premium credit program, the following guidelines must be established:

1. Insurers offering the premium credit program may apply a 5% premium credit to qualifying employers.

2. To receive the premium credit, you must:

- **a.** Provide a written statement to the insurer prior to or within 30 days after the beginning of the policy effective date each year, certifying that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14.
- **b.** At any time during the term of the policy, provide additional information to the insurer, as required, to confirm that a qualifying program has been established and is being maintained.
- **c.** Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, Article 14.
- **d.** Conduct alcohol and drug testing of prospective employees.
- **e.** Conduct alcohol and drug testing of an employee after the employee has been injured.
- **f.** Allow us to have access to the alcohol and drug testing results under d. and e. above.

3. The determination that you have established and maintain a qualifying program must be made during each policy term that you receive the premium credit.

4. Your certification and any other information relied upon by the insurer in granting the premium credit must be kept in the insurer's underwriting files and made available to the Department of Insurance upon request.

5. The premium credit may be applied after total premium has been paid for the policy period and may be revised at final audit to the employer's policy. The credit is applicable as a supplement to deviated rates and is applied in a multiplicative manner, after the application of the experience modification, and before the application of the premium discount and expense constant.

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POLICY NUMBER: **(HJUB-6E20721-A-15)**

6. You must reimburse the premium credit if it is determined that you were not in compliance with the provisions of the program.

7. Minimum premium policies are eligible for this premium credit.

8. Residual market employers are eligible to apply for this premium credit.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 06 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ARIZONA CANCELATION ENDORSEMENT

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

The **Cancelation** Condition of the policy is replaced by this Condition:

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 if you fail to pay premium when due. We must mail or deliver to you and the Industrial Commission of Arizona not less than thirty 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.

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 01 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT – CALIFORNIA

The insurance afforded by Part Two (Employers' Liability Insurance) by reason of designation of California in item 3 of the information page is subject to the following provisions:

A. "How This Insurance Applies," is amended to read as follows:

A. How This Insurance Applies

This employers' liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury means a physical injury, including 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 California.

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.

C. The "Exclusions" section is modified as follows (all other exclusions in the "Exclusions" section remain as is):

1. Exclusion 1 is amended to read as follows:

1. liability assumed under a contract.

2. Exclusion 2 is deleted.

3. Exclusion 7 is amended to read as follows:

7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.

4. The following exclusions are added:

1. bodily injury to any member of the flying crew of any aircraft.

2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 Cancelation Table

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors 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

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors 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

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors 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			

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 of 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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 05 04 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 06 03 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 06 03 03 (C)

POLICY NUMBER: (HJUB-6E20721-A-15)

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 06 06 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

CONNECTICUT NONRENEWAL ENDORSEMENT

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

Add the following to **Part Six – Conditions** of this policy:

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 via registered mail, certified mail or by mail evidenced by a certificate of mailing, or deliver to the named insured at the address shown in the policy, at least sixty (60) days advance notice of our intention not to renew.

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 03 03 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

C. 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 your immunity from civil liability under the workers compensation laws.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 04 07 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 for your final premium. 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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 10 04 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

GEORGIA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

This endorsement adds to Part Five – Premium, Condition G. Audit, the following provision:

If you do not allow us to examine and audit all of your records that relate to this policy, we may utilize a payroll amount of three times the estimated payroll for purposes of determining final 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 Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 10 06 01 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDORSEMENT

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

Part Six – Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation, Nonrenewal, and Change

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect, subject to the following:

a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.

b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practicable after receiving your request for cancellation.

Our notice will state the effective date of cancellation, which will be the later of the following:

1) 10 days from the date of mailing or delivering our notice, or

2) The effective date of cancellation stated in your notice to us.

2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium or if we nonrenew this policy, we must send to you a notice of cancellation or nonrenewal by certified mail, return receipt requested, to your last address of record at least 75 days prior to the effective date of cancellation or nonrenewal.

3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience modification or resulting from an audit of auditable coverages), limit or restrict coverage, we must mail by first class mail or deliver a notice of our action (including dollar amount of any increase in renewal premium more than 15%) to you at the last mailing address of record at least 45 days before the expiration date of this policy.

4. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days prior to the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.

5. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

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 issuance of the policy.)

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATA OF ISSUE **06-25-15** ST ASSIGN

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 12 06 01 (E)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ILLINOIS AMENDATORY ENDORSEMENT

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

Part Two – Employers Liability Insurance, Section B. (We Will Pay), Item 3. of the policy is replaced by the following:

3. For consequential bodily injury to a party to a civil union, 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 an in the course of the injured employee's employment by you; and

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. These records include ledgers, journals, registers, vouchers, contractors, 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 ends. Information developed by audit will be used to determine final premium. The National Council on Compensation Insurance has the same rights we have under this provision.

Part Six – Conditions, Section A. (Inspection) of the policy is replaced by the following:

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. The National Council on Compensation Insurance has the same rights we have under this provision.

Part Six – Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancellation is to take effect.

2. We may cancel this policy. We will mail to each named insured at the last known mailing address advance written notice stating when the cancellation is to take effect. We will maintain proof of mailing of the notice of cancellation. A copy of all such notices shall be sent to the broker or agent of record, if known, at the last known mailing address. The broker or agent of record may opt to accept notification electronically.

3. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least ten days before the cancellation is to take effect. If we cancel for any other reason, we will mail the notice:

a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;

b. At least 60 days before the cancellation is to take effect if the policy has been in force for 61 days or more.

4. If this policy has been in effect for 60 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 terms and conditions of the policy;

d. The risk originally accepted has measurably increased;

e. The Director has determined that we no longer have adequate reinsurance to meet our needs; or

f. The Director has determined that continuation of coverage could place us in violation of the laws of Ilinois.

5. Our notice of cancellation will state our reasons for cancelling.

6. The policy period will end on the day and hour stated in the cancellation notice.

Part Six – Conditions, Section E. (Sole Representative) of the policy is replaced by the following:

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, or give us notice of cancellation.

Part Six – Conditions of the policy is changed by adding the following:

F. Nonrenewal

1. We may elect not to renew the policy. If we fail to give at least 60 days notice prior to the expiration date of the current policy, the policy will automatically be extended for one year. We will mail to each named insured the nonrenewal notice at the last known mailing address. We will maintain proof of mailing of the nonrenewal notice. An exact and unaltered copy of such notice will also be sent to the named insured's producer, if known, or the producer of record at the last known mailing address. The named insured's producer, if known, or the producer of record may opt to accept notification electronically.

2. Our notice of nonrenewal will state our reasons for not renewing.

3. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:

a. You notify us or the producer 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 issuance of the policy.)

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 15 04 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 15 06 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 effect. 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 policy took effect;
   e. the Commissioner has determined that our continuation of coverage could place us in a hazardous 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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 06 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

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

The **Cancelation** Condition of the policy is replaced by the following:

Cancelation

1. You may cancel this policy. You will deliver or mail advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will deliver or mail to you not less than 75 days advance written notice stating when the cancelation is to take effect and our reason or reasons for cancelation. If we cancel for nonpayment of premium or within 60 days of the date of issuance of the policy, we will deliver or mail this notice not less than 14 days prior to the effective date of 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. After coverage has been in effect more than 60 days or after the effective date of a renewal policy, we may not cancel the policy unless cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. discovery of fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or presenting a claim under the policy;
   c. discovery of willful or reckless acts or omissions on your part increasing any hazard originally insured;
   d. changes in conditions after the effective date of the policy or any renewal substantially increasing any hazard originally insured;
   e a violation of any local fire, health, safety, building, or construction regulation or ordinance at any of your covered workplaces substantially increasing any hazard originally insured;
   f. our involuntary loss of reinsurance for the policy;
   g. a determination by the commissioner that the continuation of the policy would place us in violation of Kentucky insurance laws.

Nonrenewal

1. We may elect not to renew the policy. We will deliver or mail to you not less than 75 days advance written notice stating our intention not to renew and our reason or reasons 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 be deemed to be renewed for the ensuing policy period upon payment of the appropriate premium, and coverage will continue until you have accepted replacement coverage with another insurer, until you have agreed to the nonrenewal, or until the policy is canceled.
3. If we have delivered or mailed to you a renewal notice, bill, certificate, or policy not less than 30 days before the end of the current policy period clearly stating the amount and due date of the renewal premium charge, then the policy will terminate on the due date without further notice unless the renewal premium is received by us or our agent on or before the due date. If the policy terminates in this manner, we will deliver or mail to you within 15 days of termination at your mailing address shown in Item 1 of the Information Page a notice that

the policy was not renewed and the date on which coverage ceased to exist. Proof of mailing of the renewal premium to us or our agent on or before the due date will constitute a presumption of receipt on or before the due date.

4. If we offer to renew the policy for a premium amount more than 25% greater than the premium amount for the current policy term for like coverage and like risks, we will deliver or mail to you and your agent not less than 75 days advance written notice of the renewal premium amount. We may at our option, in order to comply with this requirement, extend the period of coverage of the current policy at the expiring premium.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 06 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

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

NOTICE OF YOUR RIGHTS

If you believe that the rates or the rating system under this policy have been incorrectly or improperly applied, you may request a review of the manner in which the rate or rating system has been applied. You must make your request in writing to us or the National Council on Compensation Insurance, Inc. (NCCI). We or NCCI has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, we or NCCI shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of your review. Your appeal is to be sent to:

Legal Division
Department of Insurance
P. O. Box 517
Frankfort, KY 40602

Your request for an appeal should include a statement of the facts and how the rates or rating system were incorrectly or improperly applied. Also, enclose copies of the results of the review and any other correspondence from us or NCCI. If your appeal shows good cause, the commissioner shall hold a hearing. The commissioner may, after the hearing, issue a final order affirming, modifying or reversing our or NCCI's action.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

LOUISIANA AMENDATORY ENDORSEMENT

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

PART FIVE – PREMIUM

Section E., Final Premium of Part Five (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 SIX – CONDITIONS

The Cancellation Condition of the policy is replaced by this Condition:

D. Cancellation

1. If coverage has not been in effect for sixty days and the policy is not a renewal, cancellation shall be effected by mailing or delivering a written notice to the first-named insured at the mailing address shown on the policy at least sixty 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 shall be mailed or delivered at least ten days prior to the effective date of cancellation. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, no insurer shall cancel a 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 or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

c. Activities or omissions on the part of the named insured 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 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 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. a. A notice of cancellation of insurance coverage by an insurer shall be in writing and shall be mailed or delivered to the first-named insured at the mailing address as shown on the policy. Notices of cancellation based on conditions 1.b. through 1.g. above shall be mailed or delivered at least thirty days prior to the effective date of the cancellation; notices of cancellations based upon condition 1.a. above shall be mailed or delivered at least ten days prior to the effective date of cancellation. The notice shall state the effective date of the cancellation.

b. The insurer shall provide the first-named insured with a written statement setting forth the reason for the cancellation where the insured requests such a statement in writing and the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying the reasons for a cancellation or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for cancellation under this endorsement.

3. Nothing in this endorsement shall require an insurer to provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance agency or other entity pursuant to a power of attorney or other agreement executed by or on behalf of the insured.

4. An insurer may decide not to renew a policy if it delivers or mails to the first-named insured at the address shown on the policy written notice it will not renew the policy. Such notice of nonrenewal shall be mailed or delivered at least sixty days before the expiration date. Such notice to the insured shall include the insured's 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 less than sixty days before expiration, coverage shall remain in effect under the same terms and conditions until sixty days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group shall 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 shall not be refusals to renew.

5. Notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy, or where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

6. If an insurer provides the notice described in paragraph 4 above and thereafter the insurer extends the policy for ninety days or less, an additional notice of nonrenewal is not required with respect to the extension.

7. An insurer shall mail or deliver to the named insured at the mailing address shown on the policy written notice of any rate increase, change in deductible, or reduction in limits or coverage at least thirty days prior to the expiration date of the policy. If the insurer fails to provide such thirty-day notice, the coverage provided to the named insured at the expiring policy's rate, terms, and conditions shall remain in effect

until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. For the purposes of this paragraph, notice is considered given thirty days following date of mailing or delivery of the notice. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

8. Paragraph 7 shall not apply to the following:

a. Changes in a rate or plan filed with the insurance rating commission and applicable to an entire class of business.

b. Changes based upon the altered nature or extent of the risk insured.

c. Changes in policy forms filed and approved with the commissioner and applicable to an entire class of business.

d. Changes 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, shall be sufficient proof of notice.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 17 06 01 (E)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Section I., **Actions Against Us**, of Part Two (Employers Liability Insurance) 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.

This Condition is added to the policy:

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 15 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

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 17 06 02 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 Occupation, 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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 19 06 01 (E)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The **Cancellation** Condition of the policy is replaced by this Condition:

D. Cancellation and Nonrenewal

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.

2. We may cancel or nonrenew this policy as follows:

a. If the policy is cancelled for nonpayment of premium, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve you by certificate of mailing, not less than (10) days advance written notice stating when the cancellation will take effect.

b. If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service upon you, no less than thirty (30) days advance written notice stating when the cancellation or nonrenewal will take effect.

Mailing this notice by certified mail to you at your mailing address last known to us creates a presumption of actual delivery of notice. You may be able to rebut this presumption by providing evidence that the notice was not delivered.

3. The effective dates of the cancellation or nonrenewal are determined as follows:

a. Except for cancellation for non-payment of premium, the policy period will end on the day and hour stated in the cancellation or nonrenewal notice, or 30 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.

b. For cancellation for non-payment of premium, the policy period will end on the day and hour stated in the cancellation notice, or 10 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 03 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because Massachusetts is listed in item 3.A of the Information Page.

Our liability to you under Section 25 of Chapter 152 of the General Laws of Massachusetts is not subject to the limit of liability that applies to Part Two (Employers Liability Insurance).

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 02 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS – ASSESSMENT CHARGE

Massachusetts General Laws, Chapter 152, Section 65, as amended by Chapter 572 of the Acts of 1985, establishes a workers compensation special fund and a workers compensation trust fund.

On behalf of the Department of Industrial Accidents (DIA), the insurance company providing workers compensation coverage is required to bill and collect an assessment charge covering the special and trust funds from insured employers and remit the amounts collected to the State Treasury.

The assessment charge, which is determined by applying a rate (subject to annual change) to the **DIA's** standard premium, **as defined and outlined in 452 CMR 7.00**, developed under your policy, is shown as a separate item on the information page of the policy. The rate may be different for private employers and for the Commonwealth and its political subdivisions.

The income derived from the assessment charge will be used to fund the operating expenses of the DIA and to fund certain employee benefits as described in Chapter 152.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact your agent or us.

You may obtain pertinent rating information by submitting a written request to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this endorsement or to us at our company address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

You may also submit a written request for a review of the method by which your classification, rates, premiums or audit results were determined. If we fail to grant or reject your request within thirty days after it is made or if you are not satisfied by the results of our review, you may submit a written request for review to the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") at the address shown in this endorsement. If the WCRIBMA fails to grant or reject your request within thirty days after it is made or if you are not satisfied with the results of the WCRIBMA review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Reserve or Settlements

You may request a loss run, which contains reserve and settlement information for claims that relate to the premium for this policy. Such a request must be in writing and should be sent to our address shown on this endorsement. We will provide you with that information within thirty (30) days of receipt of your request, and at reasonable intervals thereafter.

If you have any questions or believe that we set unreasonable reserves or made unreasonable settlements that affected your premiums or losses, you may make a written request through your agent or directly to us for a meeting with our company representative. If you are not satisfied with the results of the meeting, you may make a written appeal to the Insurance Commissioner at the address shown on the endorsement.

3. Named Insured

You are responsible for immediately reporting all changes in name or legal status to us in writing at the company address shown in this Endorsement.

If you want to add a named insured or replace the named insured with another legal entity on any policy issued through the Massachusetts Assigned Risk Pool you must submit a new Assigned Risk Pool Application, including a Confidential Request for Information Form (ERM), to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this Endorsement

4. Insured's Mailing Address

Notices relating to this Policy will be mailed or delivered to your mailing address. Your mailing address is that which is shown in Item 1 of the Information Page or in a change of address Endorsement to the Policy. You are responsible for notifying us in writing at the company address shown in this Endorsement about any change to your mailing address.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Addresses

The Workers' Compensation Rating and
Inspection Bureau of Massachusetts
Attention: Customer Service Department
101 Arch Street, 5th Floor
Boston, MA 02110
www.wcribma.org

Commissioner of Insurance
Division of Insurance
Department of Banking and Insurance
1000 Washington St 8th Floor
Boston, MA 02118-2218

Address Correspondence as follows:

Policies with a 6NUB or 7UB in their symbol, to:
Travelers Insurance Company
P.O. Box 3556
Orlando, Florida 32802-3556

Policies with a 6S59UB in their symbol, to:
Direct Assignment Operations
P.O. Box 4965
Orlando, Florida 32802-4965

Policy with a 6ZZUB in their symbol, to:
Direct Assignment Operation
P.O. Box 4964
Orlando, Florida 32802-4964

Policy with a 6S6OUB in their symbol, to:
Direct Assignment Operation
P.O. Box 4903
Orlando, Florida 32802-4903

ALL OTHER POLICIES, TO:
The Travelers Insurance Company
P.O. Box 9203
Westwood, MA 02090-9203

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 04 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS PENDING PREMIUM CHANGE ENDORSEMENT

A filing is being considered by the Massachusetts Division of Insurance which may result in premiums different from those shown on the policy. If it does, we will issue an endorsement to show the new premiums and their effective date.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 04 05 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

Section D of Part Five of the Policy is replaced by this provision:

PART FIVE

PREMIUM

D. Premium Payments 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 audit and retrospective premiums shall be paid by the due date indicated on the billing statement.**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 06 01 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MASSACHUSETTS CANCELLATION ENDORSEMENT

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

The **Cancellation** Condition of the policy is replaced by the following:

Cancellation

1. You may cancel this policy by mailing or delivering to us advance written notice requesting cancellation. Such cancellation shall not be effective until ten days after written notice is given by us to The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

2. We may cancel this policy only if based on one or more of the following reasons: (i) nonpayment of premium; (ii) fraud or material misrepresentation affecting your policy; or (iii) a substantial increase in the hazard insured against. Such cancellation shall not be effective until ten days after written notice is given by us to you and The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

3. We will mail or deliver the notice of cancellation to you at your last address, which shall be the mailing address shown in Item 1 of the Information Page or the change of mailing address shown in an Endorsement to the Policy. Pursuant to M.G.L. Chapter 175, Section 187C, a written notice of cancellation shall be deemed effective when mailed by us if we obtain a certificate of mailing receipt from the United States Postal Service showing your name and address as stated in the policy.

4. Any of these provisions that conflict with the law that controls the cancellation of this insurance 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 _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 21 03 03 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact us or your agent.

You may obtain pertinent rating information by submitting a written request to us at our address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

You may also submit a written request for a review of the method by which your rates and premiums were determined. If you are not satisfied with the results of the review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Payroll Audits

You may request a payroll audit once each calendar year. Your request must be in writing sent to our address shown in this endorsement. You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

You may request reserve and redemption information that relates to the premium for this policy. Your request must be in writing sent to our address shown in this endorsement. We will provide you with that information within thirty (30) days of receipt of your request.

If you believe that the policy premiums are excessive because we set unreasonable reserves or because of the unreasonable redemption of a claim, you may request a meeting with our management representative. Your request must be in writing sent to our address shown in this endorsement. If you are not satisfied with the results of the meeting, you may appeal to the Insurance Commissioner at the address shown in this endorsement.

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30200
Lansing, MI 48909

The Travelers Insurance Companies
1000 Travelers Tower
26555 Evergreen
Southfield, MI 48076
or
625 Kenmoor Ave SE, Suite 213
Grand Rapids, MI 49546
or
The Travelers
215 Shuman Boulevard
Naperville, IL 60563

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 21 03 04 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MICHIGAN LAW ENDORSEMENT

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

Michigan law requires that we attach this paragraph to your policy in the language specified by the statute. To help you understand the paragraph, the following definitions are added:

(1) We are "the insurer issuing this policy"

(2) You are "the insured employer"

(3) "Michigan workmen's compensation act" means the Workers' Disability Compensation Act of 1969.

(4) "Workmen's compensation" means workers' compensation

(5) "The bureau of workmen's compensation" means the Bureau of Workers' Disability Compensation.

"Notwithstanding any language elsewhere contained in this contract or policy of insurance, the accident fund or the insurer issuing this policy hereby contracts and agrees with the insured employer:

Compensation:

(a) That it will pay to the persons that may become entitled thereto all workmen's compensation for which the insured employer may become liable under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Medical services:

(b) That it will furnish or cause to be furnished to all employees of the employer all reasonable medical, surgical, and hospital services and medicines when they are needed which the employer may be obligated to furnish or cause to be furnished to his employees under the provisions of the Michigan workmen's compensation act and that it will pay to the persons entitled thereto for all such services and medicines when they are needed for all compensable injuries or compensable occupational disease happening to his employees during the life of this contract or policy;

Rehabilitation services:

(c) That it will furnish or cause to be furnished such rehabilitation services for which the insured employer may become liable to furnish or cause to be furnished under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational disease happening to his employees during the life of this contract or policy;

Funeral expenses:

(d) That it will pay or cause to be paid the reasonable expense of the last sickness and burial of all employees whose deaths are caused by compensable injuries or compensable occupational diseases happening during the life of this contract or policy and arising out of and in the course of their employment with the employer, which the employer may be obligated to pay under the provisions of the Michigan workmen's compensation act;

Scope of contract:

(e) That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all

other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations assumed:

(f) That it hereby assumes all obligations imposed upon the employer by his acceptance of the Michigan workmen's compensation act, as far as the payment of compensation, death benefits, medical, surgical, hospital care or medicine and rehabilitation services is concerned;

Termination notice:

(g) That it will file with the bureau of workmen's compensation at Lansing, Michigan, at least 20 days before the taking effect of any termination or cancelation of this contract or policy, a notice giving the date at which it is proposed to terminate or cancel this contract or policy; and that any termination of this policy shall not be effective as far as the employees of the insured employer are concerned until 20 days after notice of proposed termination or cancelation is received by the bureau of workmen's compensation;

Conflicting provisions:

(h) That all the provisions of this contract, if any, which are not in harmony with this paragraph are to be construed as modified hereby, and all conditions and limitations in the policy, if any, conflicting herewith are hereby made null and void."

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 22 00 00 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 postjudgment interest assuming that the principal amount of that judgment 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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 22 03 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MINNESOTA COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS

This endorsement changes the policy to which it is attached effective on the inception of the policy unless a different date is indicated below.

This endorsement, effective on _____ at 12:01 a.m. standard time, forms a part of

Policy No. _____ of the _____
(Name of Insurance Company)

Issued to: _____

Endorsement No. _____ _____
Authorized Representative

Under Part Six – Conditions, the following condition is added:

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

All other terms and conditions remain unchanged.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 22 06 01 (D)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 insured. 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 delivered 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.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 22 06 01 (D)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 03 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 06 01 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY**

ENDORSEMENT WC 24 06 02 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 06 04 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

MISSOURI AMENDATORY ENDORSEMENT

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

Section G., **Audit**, of Part Five (Premium) 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 or do not provide audit information as reasonably requested, we may apply an Audit Noncompliance Charge equal to estimated annual premium.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, your premium will be revised accordingly.

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.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 26 06 01 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEBRASKA CANCELATION AND NONRENEWAL ENDORSEMENT

1. You may cancel this policy within the policy period by giving notice to us, fixing the date on which the cancelation is to be effective.

2. The notice, from you, is to be sent by certified mail.

3. We are required by Nebraska Law to give notice of your intent to cancel a policy to the Nebraska Workers' Compensation Court.

4. The cancelation shall not be effective until ten (10) days after we give notice to the Nebraska Workers' Compensation Court that the policy is being canceled. However, if you have secured insurance with another insurer, the cancelation will be effective as of the effective date of such other notice of coverage.

5. We may cancel or nonrenew this policy within the policy period by giving notice in writing to you and to the Nebraska Workers' Compensation Court, fixing the date on which the cancelation or nonrenewal is to be effective.

6. The notice from us will contain a brief statement of the reasons for cancelation or nonrenewal and will be sent to you by certified mail.

7. The nonrenewal shall not be effective until thirty (30) days after the giving of notice to you and the Nebraska Workers' Compensation Court.

8. The cancelation shall not be effective until thirty (30) days after the giving of notice to you and the Nebraska Workers' Compensation Court, except the cancelation shall be effective ten (10) days after the giving of the notice if the cancelation is based on:

   a. nonpayment of premiums;

   b. failure of the insured to reimburse deductible losses as required under the policy; or

   c. failure of the insured, if covered, pursuant to the Assigned Risk Plan to comply with workplace safety laws found in Nebraska statutes.

9. All notices shall be provided in writing and shall be deemed given upon mailing by certified mail, except that we may give notice to the Nebraska Workers' Compensation Court by approved electronic means. Notice provided to the Nebraska Workers' Compensation Court by approved electronic means shall be deemed given upon receipt.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 27 06 01 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 27 06 01 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 29 03 06 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New Jersey is shown in Item 3.A. of the Information Page.

With respect to Exclusion C5, this insurance does not cover any and all intentional wrongs within the exception allowed by N.J.S.A. 34:15-8 including but not limited to, bodily injury caused or aggravated by an intentional wrong committed by you or your employees, or bodily injury resulting from an act or omission by you or your employees, which is substantially certain to result in injury.

With respect to Exclusion C7, we will defend any claim, proceeding or suit for damages where bodily injury is alleged. We have the right to investigate and settle. We will not defend or continue to defend after the applicable limits of insurance have been paid. Such policy limits include any legal costs assessed against you on behalf of your employee(s).

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to an infant under the age of 18 years in a proceeding made pursuant to Article 2 as provided in N.J.S.A. 34:15-10.

This insurance does not provide for the payment of any common law negligence damages or other damages when the provisions of Article 2 of the New Jersey Workers Compensation Law have been rejected by you and your employee(s) as provided in N.J.S.A. 34:15-9.

With respect to paragraph F, the "Other Insurance" provision is replaced with the following:

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.

This insurance, however, is excess over any other applicable insurance with respect to claims for bodily injury arising out of employer practices, policies, acts or omissions enumerated in C7 above, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 31 03 08 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New York is shown in Item 3.A of the Information Page.

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to your employees if the bodily injury arises out of and in the course of employment that is subject to and is compensable under the Workers Compensation Law of New York.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 31 03 19 (G)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

The New York Construction Classification Premium Adjustment Program (NYCCPAP) allows premium credits for some employers in the construction industry. These credits exist to recognize the difference in wage rates between employers within the same construction industries in New York.

The declarations section of this policy will show a credit of 0.00% if you are not eligible for this credit, or if you are eligible for this credit and have not yet applied for a credit. Credits are earned for average wages in excess of $23.24 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

0042	5057	5193	5429	5491	5606	6003	6229	6325	9526
3365	5059	5213	5443	5506	5610	6005	6233	6400	9527
3724	5069	5221	5445	5507	5645	6017	6235	6701	9534
3726	5102	5222	5462	5508	5648	6018	6251	7536	9539
3737	5160	5223	5473	5536	5651	6045	6252	7538	9545
5000	5183	5348	5474	5538	5701	6204	6260	7601	9549
5022	5184	5402	5479	5545	5703	6216	6306	7855	9553
5037	5188	5403	5480	5547	5709	6217	6319	8227	
5040	5190	5428							

The basis for determining the credit is the limited payroll of each employee for the number of hours worked (excluding overtime premium pay) for each construction classification (other than employees engaged in the construction of one or two-family residential housing) for the third quarter, as reported to taxing authorities, for the year preceding the policy date. Total payroll is to continue to be reported for employees engaged in the construction of one or two-family residential housing. For example:

POLICY EFFECTIVE DATE	THIRD QUARTER PAYROLL
4/1/12 thru 3/31/13	2011
4/1/13 thru 3/31/14	2012
4/1/14 thru 3/31/15	2013
4/1/15 thru 3/31/16	2014
4/1/16 thru 3/31/17	2015
4/1/17 thru 3/31/18	2016

If you have any eligible classes on your policy, you should have been notified by your insurance carrier or the New York Compensation Insurance Rating Board approximately nine months prior to the inception date of this policy. If you believe you may be eligible for a credit and have not received an application, you should immediately contact your agent, insurance carrier, or the New York Compensation Insurance Rating Board.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 31 03 19 (G)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

Credits are calculated by the New York Compensation Insurance Rating Board. You must submit a completed application to: Attention: Field Services Department, New York Compensation Insurance Rating Board, 733 Third Avenue, New York, New York 10017.

Applications must be received by the Rating Board three (3) months prior to the policy renewal effective date. The Rating Board will accept and process an application if it is received between the policy effective and expiration date, however, it must be accompanied by a letter stating the reason for the delay. Under no circumstances will an application be accepted for any policy if it is received after the expiration date of the policy. For short-term policies the application must be received prior to the expiration date of the short-term policy. If it is received after the policy expiration, no credit will be calculated.

The New York Workers Compensation and Employers Liability Insurance Manual, and not this endorsement, govern the implementation and use of the NYCCPAP.

For online entry of the information requested on this form refer to: http://cpap.nycirb.org/

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 35 03 03 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OKLAHOMA EMPLOYERS LIABILITY INTENTIONAL TORT EXCLUSION ENDORSEMENT

Part Two – Employers Liability Insurance, C – Exclusions, 5. is replaced by the following:

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury that you knew or should have known was substantially certain to occur from an act caused, committed, or aggravated by you;

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is replaced by the following condition:

D. Cancellation

1. You may cancel this policy. You must mail or deliver to us not less than 30 days advance notice stating when the cancellation is to take effect. Cancellation of coverage will be effective at 12:01 a.m. thirty (30) days after the date the cancellation notice is received by us, unless a later date is specified in the notice to us. You may cancel this policy effective less than 30 days after written notice is received by us where you have obtained other coverage or have become a self- insurer.

2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.

a. At any time during the policy period, we may cancel for nonpayment of premium. If we cancel for nonpayment of premium, we will mail notice of cancellation to you and to the Workers Compensation Commission at least 10 days before the cancellation is to take effect.

b. If we cancel this policy for a reason other than nonpayment of premium, we will mail notice of cancellation to you and to the Workers Compensation Commission at least 30 days before the cancellation is to take effect.

c. If this policy has been in effect for more than 45 business days or is a renewal policy, we may cancel for only one or more of the following reasons:

(1) Nonpayment of premium;

(2) Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted under it;

(3) Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

(4) The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

(5) A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

(6) A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;

(7) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or

(8) Loss of or substantial changes in applicable reinsurance.

3. Mailing notice of cancellation to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

4. The policy period will end on 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 inthis policy is changed by this statement to comply with the law.

Part 6 (Conditions) of the policy is amended by adding the following provisions:

F. Nonrenewal

1. If we elect not to renew this policy, we will mail or deliver written notice of nonrenewal to you at least 45 days before:

a. The expiration date of this policy; or

b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

2. Any notice of nonrenewal will be mailed or delivered to you at the mailing address shown in Item 1 of the Information Page. If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.

b. Proof of mailing will be sufficient proof of notice.

3. If notice of nonrenewal is not mailed or delivered at least 45 days before the expiration date or an anniversary date of this policy, coverage will remain in effect until 45 days after notice is given. Earned premium for such extended period of coverage will be calculated pro rata based on the rates applicable to the expiring policy.

4. We will not provide notice of nonrenewal if:

a. We, or another company within the same insurance group, have offered to issue a renewal policy; or

b. You have obtained replacement coverage or have agreed in writing to obtain replacement coverage.

5. If we have provided the required notice of nonrenewal as described above, and thereafter extend the policy for a period of 90 days or less, we will not provide an additional nonrenewal notice with respect to the period of extension.

G. Notice of Premium or Coverage Changes Upon Renewal

1. If we elect to renew this policy, we will give written notice of any premium increase, change in deductible, or reduction in limits or coverage, to you, at the mailing address shown in Item 1 of the Information Page.

2. Any such notice will be mailed or delivered to you at least 45 days before:

a. The expiration date of this policy; or

b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

3. If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.

b. Proof of mailing will be sufficient proof of notice.

4. If you accept the renewal, the premium increase or deductible, limits or coverage changes will be effective the day following the prior policy's expiration or anniversary date.

5. If notice is not mailed or delivered at least 45 days before the expiration date or anniversary date of this policy, the premium, deductible, limits and coverage in effect prior to the changes will remain in effect until the earlier of:

a. 45 days after notice is given; or

b. The effective date of replacement coverage obtained by you.

6. If you then elect not to renew, any earned premium for the resulting extended period of coverage will be calculated pro rata at the lower of the new rates or rates applicable to the expiring policy.

7. We will not provide notice of the following:

a. Changes in a rate or plan filed with or approved by the Insurance Commissioner or filed pursuant to the Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business; or

b. Changes based upon the altered nature of extent of the risk insured; or

c. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 35 06 03 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OKLAHOMA FRAUD WARNING ENDORSEMENT

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

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 36 03 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OREGON UNSAFE EQUIPMENT EXCLUSION ENDORSEMENT

Part Two (Employers Liability Insurance) does not cover bodily injury arising out of your failure to comply with a notice posted pursuant to ORS 654.082 of the Oregon Safe Employment Act or any amendment to that Act.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 36 04 06 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 01 (E)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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, starting 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 with in 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 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 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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 04 05 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

PENNSYLVANIA MERIT RATING PLAN ENDORSEMENT

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

The premium for this insurance may be subject to merit rating because your premium may be less than the amount necessary to be eligible for the uniform Experience Rating Plan.

The following premium discount or surcharge will be applied to your manual premium based on your claims during the most recent two year period for which statistics are available.

1. A 5% credit **(discount)** will be applied if you had no compensable employee lost-time injuries - **Statistical Code 9885.**
2. No credit or debit will be applied if you had one (1) compensable employee lost-time injury - **Statistical Code 9884.**
3. A 5% debit **(surcharge)** will be applied if you had two (2) or more compensable employee lost-time injuries - **Statistical Code 9886.**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 37 06 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 37 06 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 03 (A)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 04 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 Assessment	=	Act 57 of 1997 Employer Assessment Factor	**X**	Employer Assessment 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	**EMPLOYER ASSESSMENT**
See info page	**$ See info page**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

TENNESSEE PENDING LOSS COST AND ASSIGNED RISK RATE ENDORSEMENT

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

The premium for the policy is determined (in part) by the product of loss costs developed and filed by the National Council on Compensation Insurance, Inc., and/or an assigned risk loss cost multiplier developed by the Tennessee Department of Commerce and Insurance.

A loss cost filing and/or a change to the assigned risk loss cost multiplier is being considered by the proper regulatory authority. The approval and/or modification of either (or both) 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.

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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 42 03 01 (G)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 42 03 01 (G)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 shall be a cancelation of this policy effective when the other policy starts.

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 shall 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 shall, 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: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM 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 TEXAS DEPARTMENT OF INSURANCE, CONSUMER PROTECTION (111–1A), P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART 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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: **(HJUB-6E20721-A-15)**

TEXAS—AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

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

PART FIVE—PREMIUM

D. Premium Payments

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

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 43 06 01 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

UTAH WORKPLACE SAFETY PROGRAM ENDORSEMENT

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

This endorsement is to inform you that you may be required to establish a workplace safety program and of the premium increase which will occur for failure or refusal to establish such a program.

You may be required to establish such a program if:

1. You have an experience modification factor of 1.00 or higher as determined by NCCI; or

2. You have a three year loss ratio of 100% or higher.

If you are required to implement a workplace safety program, the program must include a written accident and injury reduction plan and must be reviewed annually.

Your premiums may be increased by 5% over any existing rates and premium modifications for failure or refusal to establish a workplace safety program. If an increase has been made to your premium for failure or refusal to establish a workplace safety program, the amount of the increase is listed in the schedule below.

SCHEDULE

0.00

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 43 06 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 cancellation 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 effect. Should we cancel for non-payment of premiums, we must state this as the reason for the cancellation 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 premium 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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 45 06 02 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 48 06 01 (C)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

WISCONSIN LAW ENDORSEMENT

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

II. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all the terms of this policy.

IV. If any injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. 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 purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.

2. We may cancel this policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:

a. you fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;

b. a material misrepresentation;

c. a substantial breach of the obligations, conditions or warranties under the policy; or

d. a substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.

3. If we cancel for any permissible reason other than non-payment of premium, we must deliver or mail, first class, not less than* thirty (30) days 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.

4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than* sixty (60) days advance written notice stating our intention not to renew this policy.

2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.

3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year whichever is less.

4. If we offer to renew the policy on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policy holder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after written notice is mailed or delivered, in which case, you, the policy holder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and extent of the risk insured against, including, but not limited to, a change in the classifications for the business.

* Any written agreement attached to and made a part of the policy, between the insurance carrier and policyholder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 Q5 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

OKLAHOMA STATUTORY PROVISIONS ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Oklahoma is shown in Item 3.A. of the Information Page.

The following is added to Paragraph 3. of Section **H.**, **Statutory Provisions**:

The Administrator of the Workers' Compensation Court, in the name of the State of Oklahoma, may enforce our liability under this insurance for the benefit of any person entitled to benefits payable by this insurance, either by filing a separate application or by making us a party to the original application. However, any payment in whole or in part of such benefits by you or us will be a bar to the Administrator's recovery against the other of the amount paid.

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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 46 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ILLINOIS AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Illinois is shown in Item 3.A. of the Information Page. Exclusion C., 1., of Part Two (Employers Liability) of the policy is replaced by the following:

C. Exclusions

1. is replaced by:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner.

This exclusion also does not apply to your liability to a third party by reason of a claim or suit against you by that third party for contribution under the Illinois Joint Tortfeasor Contribution Act for damages claimed against such third party as a result of injury to your employee if such liability is otherwise covered under this Part Two of the policy, and you have that liability because you have waived, in a written contract, your right to limit such liability to the amount of the workers compensation benefits paid for that injured employee under the Illinois Workers Compensation Act. This exception only applies to bodily injury by accident that occurs after that contract was made and to bodily injury by disease caused or aggravated by conditions to which the injured employee's last day of exposure occurs after that contract was made.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 17 03 03 (00)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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 provisions 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 judgment or settlement.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 29 04 11 (B)

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NEW JERSEY PREMIUM DISCOUNT ENDORSEMENT SCHEDULE Y

The New Jersey premium for this policy and the policies, if any, listed in Item 2 of the Schedule may be eligible for a discount. This endorsement shows the discount rates in Item 1 of the Schedule. The final calculation of premium discount will be determined by our Manual and your New Jersey standard premium as determined by audit.

In certain cases where New Jersey retrospective rating applies, all of the premium may not be subject to retrospective rating. In such cases:

So much of the New Jersey Standard Premium as is subject to retrospective rating shall not be subject to discount. The remainder is subject to discount and the discount is calculated as follows:

(a) Determine the discount as though none of the standard premium is subject to retrospective rating.

(b) Determine the discount as though only the premium subject to retrospective rating is discounted.

(c) The difference between (a) and (b) is the applicable premium discount.

Schedule

1. Premium Discount. The first $10,000 of the Standard Premium shall be charged in full without discount, the next $190,000 shall be subject to a discount of 8.5%, the next $1,550,000 shall be subject to a discount of 10.2%, and the remainder shall be subject to a discount of ***11.0***%.

2. Other 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 _____

DATE OF ISSUE: **06-25-15** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

This medical and indemnity deductible program is being offered to policyholders with an estimated annual premium at inception of twelve thousand dollars or more. Under this deductible program we pay all amounts in their entirety applicable to each compensable claim under Part One of the policy.

We then obtain reimbursement from you, the policyholder, subject to the limits of the deductible amount for each occurrence. You are liable to us for the deductible amount in regard to benefits paid for compensable claims, and failure by you to reimburse any deductible amounts to us shall be treated in the same manner as nonpayment of premium.

The deductibles paid by you during any one year period of insurance shall not exceed the estimated annual premium at inception for such policy of insurance. A policy written under this deductible program shall have attached the New York Benefits Deductible Endorsement WC 31 03 15 (A) to the policy. One of the following deductible amounts, per occurrence, is available for selection by you to activate this program.

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

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 from the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, 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 agent.

DEDUCTIBLE TABLE

DEDUCTIBLE PER OCCURRENCE:	
$ 100	$1,000
$ 200	$1,500
$ 300	$2,000
$ 400	$2,500
$ 500	$5,000

DATE OF ISSUE: **06-25-15**

YES, I WANT A DEDUCTIBLE OF $ _____ APPLIED TO MEDICAL AND INDEMNITY BENEFITS UNDER THE NEW YORK WORKERS COMPENSATION LAW. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with New York law, 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: _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

Alabama Policyholders

Alabama 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 $100 and a maximum of $2,500 for each accident, 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 applied.

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 producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, WC 00 06 03 (00), will then be attached to your policy to reflect the change.

If you decide that you do not want the 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.

TABLE

Workers Compensation
Available Deductibles Per Accident: $100, $200, $300, $400, $500, $1,000, $1,500, $2,000 or $2,500.

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Alabama Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Alabama 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: _____

DATE OF ISSUE: **062515**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

POLICY NUMBER: (HJUB-6E20721-A-15)

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

Colorado Policyholders

Colorado law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each claim for bodily injury by accident or disease. The deductible amount is subject to a minimum of $500 and a maximum of $15,500 as shown in the table below.

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

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 producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, WC 00 06 03(00), will then be attached to your policy to reflect the change.

If you decide that you do not want the 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

INDEMNITY AND MEDICAL BENEFITS

$500, $1,000, $1,500, $2,000, $2,500, $5,000, $10,000, $13,500, or $15,500

Yes, I want a deductible of $ _____ applied as indicated above under the Colorado Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that 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: _____

DATE OF ISSUE: **062515**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF ELECTION TO ACCEPT A BENEFIT DEDUCTIBLE AND/OR COINSURANCE PROGRAM FOR WORKERS' COMPENSATION COVERAGE IN FLORIDA

Florida Policyholders

The Florida law now permits an employer to buy Workers' Compensation Insurance with a deductible coinsurance or in a deductible coinsurance combined option. The program is applied to indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum and a maximum for each accident, depending which program is selected.

Effective January 1, 1994 the State of Florida passed in special session a $2,500 State Authorized deductible. Any amount paid by the employer in this deductible option (4) shall reduce the amount of loss that goes into Experiencing Rating of such employer. There is no premium credit applied to this program.

To prevent putting you in an uninsured position, your policy has been issued at full rates without this program being applied.

If you wish to have one of the options 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 will then be attached to your policy to reflect the change.

If you decide that you do not want this benefit deductible and/or coinsurance program to apply, or if you already have it 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 by choosing one of these options, please contact your agent.

DATE OF ISSUE: **062515**

Item #1: PROGRAM _____

AMOUNT _____

Item #2:

Program 1 - Coinsurance/Deductibles		Program 2 - Coinsurance	
Deductible Amount w/$21,000 Coinsurance	Policy Premium Reduction	Coinsurance Amount	Policy Premium Reduction
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker	$ 5,000 10,000 15,000 20,000 21,000	See Your Agent/ Broker
Use Florida Coinsurance and Deductible Endorsement WC 09 06 03.		Use Florida Deductible Endorsement WC 09 06 04.	
Program 3 - Deductibles		**Program 4 - Deductible**	
Deductible Amount	Policy Premium Reduction	Deductible $2,500 (No Policy Premium Credit)	
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker		
Use Florida Benefits Deductible Endorsement WC 09 06 05.		Use Florida Benefits Deductible Endorsement WC 09 06 05.	

Yes, I want the program/amount that I selected in Item #1 to be applied to my policy for medical and indemnity benefits under the Florida Workers' Compensation Law. I understand that the company shall pay the deductible or coinsurance amount and seek reimbursement from the employer shown below.

I understand that in accordance with Florida Laws, I have the option of modifying the above 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: _____

DATE OF ISSUE: **062515**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

Georgia Policyholders

Georgia law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each accident 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 $100 and a maximum of $2,500 for each accident, with intermediate increments as shown in the table below.

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

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Three copies of this form are provided: (1) Retain a copy for your records; (2) Send a copy to your producer to keep him/her informed of your intention; and (3) Complete and return a copy to the carrier at the service address noted above within sixty (60) days after the effective date of your policy. An endorsement, will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, 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

INDEMNITY AND MEDICAL DEDUCTIBLE PER ACCIDENT:	$100, $200, $300, $400, $500, $1,000, $1,500, $2,000 or $2,500

Yes, I want a deductible of $_____ applied to medical and benefits under the Georgia Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Georgia Law I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: **THE TRAVELERS INSURANCE COMPANIES**

DATE OF ISSUE: **062515**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR ILLINOIS WORKERS' COMPENSATION MEDICAL BENEFITS

Illinois Policyholders

Illinois law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical benefits only and applies separately to each accident, regardless of the number of people who sustain injury by such accident. The deductible amount is $1,000 for each accident.

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

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, will be then attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a medical 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 by choosing this option, please contact your agent.

Yes, I want a deductible of $1,000 applied to medical benefits under the Illinois Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

Date: _____ Employer: _____

Name: _____

Title: _____

Insurance Company: _____

DATE OF ISSUE: **06-25-15**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

Kentucky Policyholders

Kentucky 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 $100 and a maximum of $10,000 for each accident, 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 00 06 03 (00)) will then be attached to your policy to reflect the change.

If you decide that you do not want the 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 agent.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL	$100	$200	$300	$400
DEDUCTIBLE PER ACCIDENT:	$500	$,1000	$1,500	$2,500
	$5,000	$7,500	$10,000	

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Kentucky Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Kentucky 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: _____

DATE OF ISSUE: **06-25-15**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

Minnesota Policyholders

Minnesota 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 $100 and a maximum of $50,000 for each accident, 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 applied.

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 producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, (WC 00 06 03 (00)) will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, 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

MEDICAL DEDUCTIBLE	TOTAL CLAIM DEDUCTIBLE
$100	$100
$150	$150
$200	$200
$250	$250
$500	$500
$1,000	$1,000
$1,500	$1,500
$2,000	$2,000
$2,500	$2,500
$5,000	$5,000
$10,000	$10,000
$25,000	$25,000
$50,000	$50,000

Yes, I want a: **– Medical Deductible**_____ or **Total Claim Deductible**_____

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Minnesota Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Minnesota 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 OF ISSUE: **06-25-15**

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Agent's Name: _____

Policy Number: _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR NEBRASKA WORKERS' COMPENSATION MEDICAL BENEFITS

Nebraska Policyholders

Nebraska law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical 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 $500 and a maximum of $2,500 for each accident, 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 26 06 02 (00)) will then be attached to your policy to reflect the change.

If you decide that you do not want the 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 agent.

DEDUCTIBLE TABLE

DEDUCTIBLE PER ACCIDENT:	**$500**	**$1,000**	**$1,500**	**$2,000**	**$2,500**

Yes, I want a deductible of $_____ applied to medical benefits under the Nebraska Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

DATE OF ISSUE: **062515**

I understand that in accordance with Section 48.121.01 of the Nebraska 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: _____

OKLAHOMA WORKERS COMPENSATION DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires insurers to offer a medical claim deductible on all Oklahoma workers compensation policies. Oklahoma law allows insurers to offer a policy with both medical and indemnity deductibles. You may choose a medical deductible only, an indemnity deductible only, or you may choose both a medical and indemnity deductible. You may also choose to reject both.

Five medical deductible options are available. You are not required to select the medical deductible option, but if you choose to exercise this option, you may choose only one deductible amount. Please carefully review the requirements for the medical deductible option outlined below.

Five indemnity deductible options are available. You are not required to select the indemnity deductible option, but if you choose to exercise this option, you may choose only one deductible amount and it must match the medical deductible amount, if you also selected a medical deductible. Please carefully review the requirements for the indemnity deductible option outlined below.

MEDICAL DEDUCTIBLE OPTIONS

The medical claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the medical benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF MEDICAL DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the medical deductible amount to the injured worker or the insurer.

If you choose a medical deductible option, the insurer will pay the entire cost of medical bills directly to the provider of the services and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty (60) days of a written demand. If you fail to reimburse the insurer within sixty (60) days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

MEDICAL DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes, I have read the medical deductible information outlined above and want the following medical deductible amount to apply to medical claims under Oklahoma workers' compensation law. I understand that this medical deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

- ☐ $ 500
- ☐ $1,000
- ☐ $1,500
- ☐ $2,000
- ☐ $2,500

☐ No, I do not want the medical deductible described in this notice.

INDEMNITY DEDUCTIBLE OPTIONS

The indemnity claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the indemnity benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF INDEMNITY DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the indemnity deductible amount to the injured worker or the insurer.

If you choose an indemnity deductible option, the insurer will pay the entire cost of indemnity benefits and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty (60) days of a written demand. If you fail to reimburse the insurer within sixty (60) days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

INDEMNITY DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes, I have read the indemnity deductible information outlined above and want the following indemnity deductible amount to apply to indemnity claims under Oklahoma workers compensation law. I understand that this indemnity deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee. I understand that the indemnity deductible amount chosen must match the medical deductible amount chosen, if I also selected a medical deductible.

- ☐ $ 500
- ☐ $1,000
- ☐ $1,500
- ☐ $2,000
- ☐ $2,500

☐ No, I do not want the indemnity deductible described in this notice.

NAMED INSURED _____

ADDRESS _____

TITLE _____

SIGNATURE _____

DATE _____

POLICY NUMBER: **(HJUB-6E20721-A-15)** POLICY PERIOD: **06-06-15** to **06-06-16**

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

Form 35-4A

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

South Carolina Policyholders:

South Carolina 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 $100 and a maximum of $2,500 for each accident, 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 applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain a copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement (WC 00 06 03) will be then 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 agent.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL
DEDUCTIBLE PER ACCIDENT: $100, $200, $300, $400, $500, $1,000, $1,500, $2,000, or $2,500

DATE OF ISSUE: **06-25-15**

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the South Carolina Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with the South Carolina 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: _____

TRAVELERS

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.

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

Workers Compensation
Acknowledgement Form:

POLICY NUMBER: **(HJUB-6E20721-A-15)**

POLICY EFFECTIVE DATE: **06-06-15**

IMPORTANT MESSAGE TO INSUREDS

ACKNOWLEDGEMENT FORM REQUIREMENTS

Dear Insured:

Colorado Insurance Regulation 5-1-11, Risk Modification Plans, allows premium credits to employers who have IMPLEMENTED Certified Workers Compensation Risk Management Programs.

Premium credits for eligible employers are to be applied by the attachment of endorsement WC 05 04 03 (00) to the policy. 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.

In order to obtain the premium credit you – the Employer – must complete and sign the bottom portion of this form with the requested information. Retain a copy for your records and send your agent or producer a copy. Your agent or producer will forward a copy to your Insurer. An endorsement, will then be attached to your policy to reflect the credit.

For a complete explanation of how these programs operate and the savings, please contact your agent or producer.

- ☐ **I have implemented a Certified Workers Compensation Risk Management Program****
- ☐ I have NOT implemented a Certified Workers Compensation Risk Management Program
- ☐ **I have selected a Designated Medical Provider**

  PROVIDER: _____
- ☐ I have NOT selected a Designated Medical Provider.

** A copy of your Workers Compensation **Colorado Premium Cost Containment Certificate** must be forwarded to your Insurer.

Date: _____ Employer: _____

Name: _____

Title: _____

Signature: _____

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: **(HJUB-6E20721-A-15)** Effective Date of Policy: **06-06-15**

I am submitting a copy of my workplace safety program that meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventative maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any misleading or untrue information. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that if I knowingly and willfully falsify or conceal a material fact, make a false, fictitious or fraudulent statement or representation; or make or use any false document knowing the document to contain any false, fictitious or fraudulent entry or statement to my carrier of workers compensation insurance under Section 442, Florida Statutes, I will be guilty of a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes, and will be subject further to a penalty in the amount of $500 a day, not to exceed $50,000 for each occurrence; and

I am also aware that if I, in any matter within the jurisdiction of the division, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent entry, that I commit a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes. Moreover, I understand that an employer who commits such an act will be subject further to a penalty in the amount of $500 a day, not to exceed $50,000 for each occurrence.

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.

_____
(Signature)

_____
(Print Name and Title)

_____
(Date)

State of Florida

County of _____

Sworn to, or affirmed, and subscribed before me

this _____ day of _____

20 _____, by _____

_____
(Signature of Notary)

_____
(Expiration Date and Number)

W09N8B05

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

IMPORTANT NOTICE

RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT – ILLINOIS

The Illinois Religious Freedom Protection and Civil Union Act provides that persons of the same or opposite sex who enter into a civil union must be afforded the same obligations, protections, and legal rights as married persons. This law became effective June 1, 2011, and is designed to ensure that civil unions and marriage are treated identically under Illinois law. In accordance with law, this policy will be interpreted to provide the same benefits and protections to persons in a civil union or in a marriage.

ACCOUNT NAME:
BC TECHNICAL, INC.
7172 S AIRPORT RD
WEST JORDAN UT 84084

POLICY NUMBER: **(HJUB-6E20721-A-15)**
EFFECTIVE DATE: **06-06-15**

IMPORTANT NOTICE – SCHEDULE RATING – MISSOURI

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.

A schedule rating factor applies to your policy as follows:

Schedule Rating Criteria **Schedule Rating Factor**

A. Premises – conditions, care
(e.g., traffic areas kept clear and free of obstructions, adequate lighting)
Reasons/Basis:

+.00

B. Return to Work Program
(e.g., formal or informal program, workforce potential for Return to Work, transitional or light duty lists, designated responsible individual, injured worker progress tracking)
Reasons/Basis:

PER RC, INSURED HAS EFFECTIVE RTW PROGRAM AND TRIES TO HAVE LIGHT DUTY AVAILABLE AT ALL TIMES. **-.15**

C. Management Cooperation With Insurance Carrier
(e.g., timely claim reporting, responsiveness to recommendations and/or Company requests for information)
Reasons/Basis:

+.00

D. Safety Program
(e.g., written safety program, accident investigation, safety review and improvement process, use of Personal Protective Equipment required, designated safety coordinator)
Reasons/Basis:

FORMAL SAFETY PROGRAM THAT IS EFFECTIVE ESPECIALLY TRAINING IN MATERIAL HANDLING AND USING LIFTING AIDS **-.10**

E. Employee Selection, Training, Supervision
(e.g., skill level of workforce, drug testing, pre-employment physicals, annual turnover, training in safe work practicesand procedures, safety communications)
Reasons/Basis:

+.00

F. Expense Reduction

Reasons/Basis:

+.00

Total Schedule Rating Factor -.25

State of New York
Determination of Classification Change from 10/1/2010 Rates

Company Name	Company Abreviation	Company LCM
Charter Oak Fire Insurance Company	COF	1.052
Travelers Indemnity Company of America	TIA	1.118
Travelers Indemnity Company of Connecticut	TCT	1.183
Travelers Indemnity Company	IND	1.249
NIPPONKOA Insurance Company	JFM	1.315
Travelers Casualty and Surety Company	ACR	1.315
Travelers Property Casualty Company of America	TIL	1.315
Travelers Casualty Insurance Company of America	ACJ	1.381
Phoenix Insurance Company	PHX	1.446

"If you were insured with a **different carrier** last year, compare the current loss costs and multiplier to those used by your prior carrier".

To determine rate change from previous policy to current policy

		Current Company						
		COF	TIA	TCT	IND	ACR, JFM & TIL	ACJ	PHX
Proposed Company	COF	1.000	0.941	0.889	0.842	0.800	0.762	0.728
	TIA	1.063	1.000	0.945	0.895	0.850	0.810	0.773
	TCT	1.125	1.058	1.000	0.947	0.900	0.857	0.818
	IND	1.187	1.117	1.056	1.000	0.950	0.904	0.864
	ACR, JFM & TIL	1.250	1.176	1.112	1.053	1.000	0.952	0.909
	ACJ	1.313	1.235	1.167	1.106	1.050	1.000	0.955
	PHX	1.375	1.293	1.222	1.158	1.100	1.047	1.000

Note: To obtain the classification percentage change, apply the company factor from the above grid to the loss cost classification percentage in the attached pages. (Small differences may exist due to rounding).

Numerical Example:
Current Company = Travelers Indemnity Company of America (TIA)
Proposed Company = Travelers Indemnity Company (IND)
Company Factor = 1.117
Class = 8742 (Loss Cost Classification Factor = 1.083)
Classification Percentage Change = (1.117 X 1.083) - 1.000
=1.209 - 1.000
= .209 or +20.9%

Narrative Example

Take the change in decimal form for class 8742 from the attached pages which is 1.083 then multiply by the company factor of 1.117 determined from a current company of TIA and a proposed company of IND.

(1.117 X 1.083) - 1.000

which indicates a 20.9% increase from the October 2009 rates. If the result of the multiplication was greater than 1.000, then the result is an increase. If the result of the multiplication is less than 1.000; this implies a decrease.

NEW YORK WORKERS COMPENSATION

October 1, 2011 LOSS COST REVISION

EXPLANATORY MEMORANDUM

An overall loss cost level increase of 9.1%, which includes an increase of 9.3% in the average manual loss cost level and no change in the loss costs for terrorism and natural disasters and catastrophic industrial accidents, has been approved by the New York State Insurance Department to become effective on October 1, 2011.

Loss Experience – The latest two policy years of experience produced a 4.6% increase in the overall loss cost level.

Legislative and Regulatory Changes – This revision includes an estimate of the latest cost of the increases in the maximum weekly benefits that were set forth in the 2007 workers compensation reform legislation. In addition, changes promulgated by the Workers' Compensation Board in the inpatient hospital fee schedule and in the evaluation and management physician service fees are also contained in this revision. The overall impact of the these changes is an increase of 3.3% in manual loss costs.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a continuing small decrease in claim frequency and an upward trend in both indemnity and medical claim costs. Combined with a projected wage trend, a 2.0% net trend factor was approved.

Catastrophe Provision – This revision contains no changes in the loss cost for terrorism and in the loss cost for natural disasters and catastrophic industrial accidents.

Classification Loss Costs – Although the average manual loss cost level is increasing by 9.3%, individual classification loss cost changes are based on the most recently available loss experience for each classification. Both increases and decreases from the current loss costs have been actuarially calculated for each class. This process ensures that each classification loss cost reflects the appropriate level relative to the experience of the other classifications.

State of New York
Loss Costs Percentage Change (10/1/2011 vs. 10/1/2010)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
0005	-7.2%	0.928	2070	-7.3%	0.927	2670	26.7%	1.267
0006	2.3%	1.023	2081	15.0%	1.150	2683	10.1%	1.101
0007	11.3%	1.113	2089	19.8%	1.198	2688	-10.7%	0.893
0031	7.6%	1.076	2095	1.4%	1.014	2689	7.9%	1.079
0034	-3.0%	0.970	2101	5.3%	1.053	2702	29.5%	1.295
0035	15.1%	1.151	2105	8.4%	1.084	2710	19.8%	1.198
0042	8.7%	1.087	2111	-16.1%	0.839	2714	32.2%	1.322
0050	-1.8%	0.982	2112	24.8%	1.248	2731	4.5%	1.045
0106	0.8%	1.008	2114	4.3%	1.043	2735	8.1%	1.081
0251	7.7%	1.077	2121	-7.0%	0.930	2737	21.4%	1.214
0767	20.5%	1.205	2143	-1.0%	0.990	2759	37.4%	1.374
0771	19.4%	1.194	2150	-0.1%	0.999	2790	37.5%	1.375
0908	-2.0%	0.980	2157	15.5%	1.155	2802	14.0%	1.140
0909	31.4%	1.314	2172	7.6%	1.076	2816	37.4%	1.374
0912	15.1%	1.151	2211	3.8%	1.038	2817	9.3%	1.093
0913	30.6%	1.306	2286	8.5%	1.085	2818	12.5%	1.125
0917	21.8%	1.218	2288	18.6%	1.186	2835	19.2%	1.192
1170	10.5%	1.105	2302	12.0%	1.120	2841	-1.0%	0.990
1320	5.5%	1.055	2303	37.5%	1.375	2881	-3.5%	0.965
1430	18.0%	1.180	2305	9.9%	1.099	2883	4.0%	1.040
1438	-6.4%	0.936	2362	-3.4%	0.966	2913	17.1%	1.171
1439	23.8%	1.238	2380	26.2%	1.262	2916	11.4%	1.114
1452	5.5%	1.055	2383	7.3%	1.073	2923	-5.7%	0.943
1463	37.3%	1.373	2387	9.4%	1.094	2942	10.6%	1.106
1470	0.2%	1.002	2388	14.2%	1.142	3004	37.4%	1.374
1624	-3.8%	0.962	2402	15.8%	1.158	3018	37.4%	1.374
1701	12.0%	1.120	2413	5.2%	1.052	3022	28.7%	1.287
1710	-7.3%	0.927	2416	11.7%	1.117	3027	-3.3%	0.967
1741	0.1%	1.001	2417	20.1%	1.201	3028	11.7%	1.117
1747	21.9%	1.219	2501	-0.9%	0.991	3030	3.7%	1.037
1748	17.7%	1.177	2503	11.0%	1.110	3040	-1.4%	0.986
1809	27.7%	1.277	2534	8.5%	1.085	3041	-1.0%	0.990
1810	28.2%	1.282	2553	10.1%	1.101	3042	9.8%	1.098
1853	11.8%	1.118	2570	15.3%	1.153	3060	37.4%	1.374
1860	21.5%	1.215	2571	22.0%	1.220	3064	-10.4%	0.896
1924	6.3%	1.063	2576	28.6%	1.286	3066	-1.2%	0.988
1925	37.4%	1.374	2578	10.8%	1.108	3067	20.6%	1.206
2001	-16.4%	0.836	2590	4.7%	1.047	3076	29.6%	1.296
2002	15.3%	1.153	2591	11.1%	1.111	3081	-5.9%	0.941
2003	2.4%	1.024	2593	-10.2%	0.898	3085	18.4%	1.184

State of New York
Loss Costs Percentage Change (10/1/2011 vs. 10/1/2010)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
2014	14.6%	1.146	2594	-8.5%	0.915	3110	27.7%	1.277
2021	-9.0%	0.910	2600	15.0%	1.150	3111	37.4%	1.374
2039	-16.5%	0.835	2623	17.2%	1.172	3113	4.8%	1.048
2041	-2.4%	0.976	2640	37.4%	1.374	3114	10.6%	1.106
2065	4.6%	1.046	2660	20.0%	1.200	3118	12.2%	1.122
3122	4.4%	1.044	3643	-4.0%	0.960	4282	28.9%	1.289
3126	-9.2%	0.908	3647	0.4%	1.004	4298	9.0%	1.090
3129	37.5%	1.375	3648	14.3%	1.143	4299	13.8%	1.138
3132	26.8%	1.268	3681	4.6%	1.046	4301	11.7%	1.117
3145	7.1%	1.071	3685	13.2%	1.132	4304	16.3%	1.163
3146	-9.8%	0.902	3686	6.6%	1.066	4307	2.4%	1.024
3169	9.3%	1.093	3724	11.2%	1.112	4310	4.3%	1.043
3179	3.0%	1.030	3726	10.6%	1.106	4312	-5.6%	0.944
3188	14.3%	1.143	3737	7.0%	1.070	4351	0.6%	1.006
3190	2.3%	1.023	3807	-6.1%	0.939	4352	-5.2%	0.948
3191	22.3%	1.223	3808	20.0%	1.200	4360	0.0%	1.000
3200	1.3%	1.013	3821	-13.8%	0.862	4361	11.6%	1.116
3220	37.3%	1.373	3823	31.9%	1.319	4362	36.1%	1.361
3227	13.4%	1.134	3824	1.8%	1.018	4410	7.6%	1.076
3241	11.7%	1.117	3826	10.0%	1.100	4420	19.6%	1.196
3255	18.6%	1.186	3827	11.7%	1.117	4431	3.2%	1.032
3257	2.3%	1.023	3830	20.8%	1.208	4432	9.5%	1.095
3270	1.4%	1.014	3832	-6.2%	0.938	4439	3.3%	1.033
3300	15.4%	1.154	3865	3.7%	1.037	4452	6.0%	1.060
3303	11.8%	1.118	3881		A	4459	-10.2%	0.898
3307	37.3%	1.373	4000	10.5%	1.105	4470	-10.0%	0.900
3315	15.5%	1.155	4024	22.7%	1.227	4475	25.6%	1.256
3336	27.5%	1.275	4034	37.4%	1.374	4476	29.0%	1.290
3365	-7.4%	0.926	4038	15.3%	1.153	4479	5.2%	1.052
3372	11.8%	1.118	4053	37.4%	1.374	4491	11.6%	1.116
3381	31.2%	1.312	4061	37.4%	1.374	4493	19.5%	1.195
3383	13.4%	1.134	4062	11.2%	1.112	4511	16.1%	1.161
3384	3.2%	1.032	4101	8.0%	1.080	4557	6.5%	1.065
3385	3.7%	1.037	4111	26.8%	1.268	4558	22.5%	1.225
3400	22.0%	1.220	4112	37.1%	1.371	4561	1.5%	1.015
3507	37.3%	1.373	4114	8.5%	1.085	4568	0.5%	1.005
3515	3.9%	1.039	4130	12.2%	1.122	4583	36.3%	1.363
3548	11.6%	1.116	4131	11.8%	1.118	4597	3.4%	1.034
3559	22.9%	1.229	4133	4.6%	1.046	4611	9.2%	1.092
3561	8.9%	1.089	4150	7.5%	1.075	4628	7.8%	1.078

State of New York
Loss Costs Percentage Change (10/1/2011 vs. 10/1/2010)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
3574	18.1%	1.181	4207	4.1%	1.041	4635	15.9%	1.159
3581	7.9%	1.079	4239	10.8%	1.108	4653	18.8%	1.188
3612	-0.3%	0.997	4240	10.2%	1.102	4665	10.0%	1.100
3620	4.1%	1.041	4243	25.9%	1.259	4692	17.6%	1.176
3629	0.6%	1.006	4244	10.2%	1.102	4693	37.1%	1.371
3632	14.9%	1.149	4250	-10.0%	0.900	4710	6.2%	1.062
3634	14.1%	1.141	4251	20.3%	1.203	4712	33.3%	1.333
3635	13.7%	1.137	4263	-2.9%	0.971	4720	14.9%	1.149
3638	8.5%	1.085	4273	14.7%	1.147	4751	7.7%	1.077
3642	10.3%	1.103	4279	4.4%	1.044	4767	4.5%	1.045
4771	-5.9%	0.941	5547	6.8%	1.068	7016	2.8%	1.028
4825	23.1%	1.231	5606	0.2%	1.002	7024	2.3%	1.023
4828	-13.8%	0.862	5610	29.0%	1.290	7038	1.2%	1.012
4829	26.4%	1.264	5645	-3.5%	0.965	7046	3.3%	1.033
4902	10.3%	1.103	5648	28.8%	1.288	7047	-16.1%	0.839
4923	-4.0%	0.960	5651	-17.4%	0.826	7050	-14.1%	0.859
5000	-4.7%	0.953	5701	29.4%	1.294	7090	1.4%	1.014
5022	11.2%	1.112	5703	21.0%	1.210	7098	3.4%	1.034
5037	26.0%	1.260	5709	-17.4%	N / A	7099	-12.3%	0.877
5040	8.9%	1.089	5951	6.3%	1.063	7133	-4.8%	0.952
5057	-2.3%	0.977	5954	18.7%	1.187	7197	11.2%	1.112
5059	-17.4%	0.826	6003	2.8%	1.028	7201	29.6%	1.296
5069	7.1%	1.071	6005	29.5%	1.295	7207	19.5%	1.195
5102	15.0%	1.150	6017	1.9%	1.019	7219	18.8%	1.188
5160	11.8%	1.118	6018	7.4%	1.074	7231	36.2%	1.362
5183	17.2%	1.172	6045	7.5%	1.075	7242	36.2%	1.362
5184	19.7%	1.197	6204	-3.3%	0.967	7309	-2.7%	0.973
5188	28.9%	1.289	6216	29.2%	1.292	7313	2.7%	1.027
5190	8.3%	1.083	6217	-0.2%	0.998	7317	-2.6%	0.974
5191	6.3%	1.063	6229	-1.0%	0.990	7327	6.8%	1.068
5192	27.3%	1.273	6233	-17.5%	0.825	7333	14.6%	1.146
5193	24.5%	1.245	6235	7.4%	1.074	7335	14.6%	1.146
5213	3.5%	1.035	6251	5.7%	1.057	7337	-2.8%	0.972
5221	9.7%	1.097	6252	-9.6%	0.904	7364	12.7%	1.127
5222	16.4%	1.164	6260		A	7366	6.8%	1.068
5223	23.7%	1.237	6306	29.3%	1.293	7367	21.6%	1.216
5348	18.1%	1.181	6319	8.3%	1.083	7368	36.2%	1.362
5402	17.5%	1.175	6325	6.0%	1.060	7370		C
5403	6.9%	1.069	6400	4.8%	1.048	7377	21.0%	1.210
5428	29.4%	1.294	6504	19.3%	1.193	7380	18.2%	1.182

State of New York
Loss Costs Percentage Change (10/1/2010 vs. 10/1/2009)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
5429	24.8%	1.248	6701	7.5%	1.075	7390	5.9%	1.059
5443	6.4%	1.064	6801	6.5%	1.065	7394	-7.7%	0.923
5445	14.1%	1.141	6811	0.7%	1.007	7395	-8.0%	0.920
5462	0.8%	1.008	6824	-0.2%	0.998	7398	-12.1%	0.879
5473	4.7%	1.047	6826	6.8%	1.068	7403	3.6%	1.036
5474	-1.3%	0.987	6834	1.1%	1.011	7405	22.9%	1.229
5479	19.8%	1.198	6836	11.3%	1.113	7421	-13.8%	0.862
5480	29.3%	1.293	6843	6.7%	1.067	7422	24.6%	1.246
5491	1.0%	1.010	6854	6.6%	1.066	7431	28.9%	1.289
5506	0.8%	1.008	6872	-3.1%	0.969	7445	5.0%	1.050
5507	29.4%	1.294	6874	-2.1%	0.979	7453	5.3%	1.053
5508	-17.4%	0.826	6875	-1.5%	0.985	7502	11.8%	1.118
5536	1.2%	1.012	6882	-0.4%	0.996	7515	0.9%	1.009
5538	6.2%	1.062	6884	6.7%	1.067	7520	24.8%	1.248
5545	-7.2%	0.928	6885	6.7%	1.067	7536	15.8%	1.158
7538	-17.4%	0.826	8116	29.4%	1.294	8833	23.6%	1.236
7539	10.6%	1.106	8199	13.5%	1.135	8838	23.3%	1.233
7542	30.2%	1.302	8209	23.8%	1.238	8840	2.4%	1.024
7570	5.0%	1.050	8215	-1.1%	0.989	8854	25.9%	1.259
7580	7.6%	1.076	8227	11.5%	1.115	8857	36.0%	1.360
7590	-13.7%	0.863	8232	7.0%	1.070	8864	23.0%	1.230
7600	11.4%	1.114	8235	9.3%	1.093	8865	13.8%	1.138
7601	-17.4%	0.826	8263	-4.6%	0.954	8866	21.9%	1.219
7610	2.9%	1.029	8264	17.8%	1.178	8868	10.0%	1.100
7710	20.5%	1.205	8265	5.9%	1.059	8969	10.0%	1.100
7711		E	8280	19.0%	1.190	8871	-2.1%	0.979
7716		E	8288	3.2%	1.032	8901	-12.2%	0.878
7720	28.6%	1.286	8291	11.0%	1.110	9014	4.4%	1.044
7723	4.7%	1.047	8292	23.9%	1.239	9015	13.1%	1.131
7855	-17.5%	0.825	8293	36.2%	1.362	9016	3.9%	1.039
7998	9.2%	1.092	8350	14.8%	1.148	9019	29.5%	1.295
7999	5.0%	1.050	8353	17.6%	1.176	9025	31.4%	1.314
8001	6.5%	1.065	8381	-11.2%	0.888	9026	4.3%	1.043
8006	2.5%	1.025	8382	2.0%	1.020	9027	25.5%	1.255
8008	0.0%	1.000	8385	4.2%	1.042	9028	7.5%	1.075
8012	28.0%	1.280	8391	8.8%	1.088	9029	25.9%	1.259
8013	7.7%	1.077	8392	23.3%	1.233	9030	10.7%	1.107
8016	13.0%	1.130	8394	10.0%	1.100	9040	4.1%	1.041
8017	4.0%	1.040	8500	14.5%	1.145	9044	28.8%	1.288
8018	7.0%	1.070	8601	27.8%	1.278	9048	-1.6%	0.984

State of New York
Loss Costs Percentage Change (10/1/2011 vs. 10/1/2010)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
8021	-9.4%	0.906	8709	-2.5%	0.975	9051	3.6%	1.036
8025	9.0%	N/A	8719	5.5%	1.055	9052	6.6%	1.066
8031	6.0%	1.060	8720	28.8%	1.288	9055	14.1%	1.141
8032	-1.9%	0.981	8726	12.3%	1.123	9058	12.6%	1.126
8033	10.0%	1.100	8731	16.7%	1.167	9059	8.7%	1.087
8034	7.8%	1.078	8742	8.3%	1.083	9060	22.2%	1.222
8039	-3.7%	0.963	8745	29.8%	1.298	9061	11.8%	1.118
8043	-15.2%	0.848	8747	-8.3%	0.917	9063	2.3%	1.023
8044	9.1%	1.091	8748	6.4%	1.064	9065	8.6%	1.086
8046	20.3%	1.203	8751	14.4%	1.144	9071	7.3%	1.073
8047	29.2%	1.292	8755	5.8%	1.058	9072	7.3%	1.073
8048	-12.6%	0.874	8800	2.9%	1.029	9074	0.7%	1.007
8072	4.0%	1.040	8802	8.7%	1.087	9088	13.1%	1.131
8090	30.6%	1.306	8803	-9.1%	0.909	9089	4.5%	1.045
8102	-6.0%	0.940	8809	5.3%	1.053	9093	31.3%	1.313
8103	6.1%	1.061	8810	5.9%	1.059	9101	8.7%	1.087
8105	-2.2%	0.978	8820	15.4%	1.154	9102	-16.8%	0.832
8106	29.6%	1.296	8829	13.4%	1.134	9149	2.1%	1.021
8107	-10.1%	0.899	8831	0.7%	1.007	9157	25.4%	1.254
8111	2.3%	1.023	8832	7.0%	1.070	9158	20.2%	1.202
9159	24.1%	1.241						
9160	7.7%	1.077						
9178	1.9%	1.019						
9179	30.0%	1.300						
9180	8.5%	1.085						
9182	6.6%	1.066						
9186	-8.1%	0.919						
9220	13.3%	1.133						
9402	15.1%	1.151						
9403	29.3%	1.293						
9410	25.8%	1.258						
9501	-1.6%	0.984						
9505	18.0%	1.180						
9519	9.2%	1.092						
9521	1.9%	1.019						
9522	18.3%	1.183						
9526	29.4%	1.294						
9527	29.4%	1.294						
9534	-17.4%	0.826						
9539	19.7%	1.197						

State of New York
Loss Costs Percentage Change (10/1/2011 vs. 10/1/2010)

Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor	Class Code	Percentage Change	Loss Cost Classification Factor
9545	-5.6%	0.944						
9549	0.6%	1.006						
9552	-6.5%	0.935						
9553	8.0%	1.080						
9585	5.9%	1.059						
9586	10.3%	1.103						
9600	9.0%	1.090						
9610	-16.5%	0.835						
9620	18.0%	1.180						

LEGEND

A – Loss cost, etc., for each individual risk shall be obtained from the Rating Board.

C – Refer to Miscellaneous Values in the manual for loss costs.

E – Refer to Volunteer Firefighters schedule for loss costs. Loss cost change is the same for all population groups in this class.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: (HJUB-6E20721-A-15)

NOTICE OF ELECTION TO ACCEPT THE OREGON EMPLOYER PAID MEDICAL CLAIMS

This notice applies only to medical benefits provided by Part One (Workers Compensation Insurance) because Oregon is shown in Item 3.A. of the Information Page.

1. Oregon law allows you to reimburse us up to a defined amount for medical services we have paid for any accepted nondisabling claim if you so choose. This defined amount is determined by the Workers' Compensation Division, Department of Consumer and Business Services, and is subject to an annual adjustment ("maximum reimbursable amount"), published annually by the Oregon Department of Consumer and Business Services in Bulletin No. 345.

2. The current maximum reimbursable amount is $1,900 per claim, but you can choose an amount lower than the maximum.

3. A nondisabling claim is defined as one where the injured person does not receive any lost time benefits.

4. If you choose to reimburse us for these medical payments made under this policy, you must still report the injury to us in the same manner that other injuries are reported but the amount paid by you will not be used in your subsequent experience rating modifications or otherwise be used to make charges against you. **Note that this reimbursement has no advantage unless your premium at least meets the experience rating threshold.**

5. If you choose to reimburse us for these medical payments made under this policy: (1) Complete the form below within thirty days of receipt of this notice; (2) Retain a copy for your records; and (3) Send a copy to us and your producer to inform him/her of your intention. An endorsement will then be attached to your policy to reflect your election.

6. Your election to participate in this program means that you agree to receive a monthly bill for the payments we made on your accepted nondisabling claims which are eligible for reimbursement. Please return a copy of your billing statement and payment within thirty days of receipt of the bill. Your failure to reimburse us will be deemed notice to us that you have decided to not participate in this program for that billing period. Notwithstanding, you will continue to receive monthly billing on any claim eligible for reimbursement for up to twenty-seven months of the inception of the policy period.

7. The bill may use the term "deductible" in reference to the Oregon Employer Paid Medical Claims program billing.

8. **If you decide that you do not want to participate in the Oregon Employer Paid Medical Claims program, you may simply disregard this notice.** You are deemed to have chosen not to participate in this program if you fail to complete this notice and return it within thirty days of your receipt. Your policy will continue in force as issued. You may send this form in any time during the policy period if you change your mind going forward.

9. A new notice of election to accept the Oregon Employer Paid Medical Claims program will be provided to you on an annual basis for applicable renewal policies.

Yes, I wish to reimburse medical payments made on nondisabling claims as indicated below. Per claim reimbursement amount (choose one):

☐ $200; ☐ $300; ☐ $400; ☐ $500; ☐ $600; ☐ $700; ☐ $800; ☐ $900; ☐ $1000;
☐ $1100; ☐ $1200; ☐ $1300; ☐ $1400; ☐ $1500; ☐ $1600; ☐ $1700; ☐ $1800; ☐ $1900

Date: _____

Employer:
Name:
Title:
Signature:

Insurance Company: _____

POLICY NUMBER: **(HJUB-6E20721-A-15)**

AN INTRODUCTION TO WORKERS COMPENSATION

INTRODUCTION

In accordance with the intent of the Oregon law, this booklet was prepared for voluntary distribution to Oregon employers by the insurance industry. In it, you will find answers to basic questions about workers compensation insurance.

NATIONAL COUNCIL ON COMPENSATION INSURANCE (NCCI)

The National Council on Compensation Insurance is a voluntary, non-profit, statistical, research and ratemaking organization licensed under Oregon Revised Statutes 737.350. Supported by the insurance industry, NCCI's primary functions are the preparation and administration of rates, rating plans, and systems for workers compensation insurance. In Oregon, the NCCI prepares a schedule of rates for insureds in the assigned risk plan, subject to insurance department approval, and acts in an advisory capacity for insurers writing the rest of the business in the state.

As the rating organization, it is NCCI's obligation to collect payroll and loss information, by individual classification, for each workers compensation insurance policy in the state of Oregon. In addition, the rating organization will perform inspections at employers' premises to determine the proper classifications, perform test audits, promulgate experience rating modifications, and administer the Workers Compensation Insurance Plan (WCIP) for those employers unable to obtain coverage voluntarily.

WORKERS COMPENSATION RATES

NCCI uses the collected payroll and loss data to actuarially determine that portion of each individual classification rate necessary to pay the losses. This amount is called the pure premium. Oregon insurers may use the pure premiums determined by NCCI or their own when preparing their rates. Each carrier applies its own 'factor' to provide for the additional costs for taxes, licenses, fees, acquisition and field supervision, and other company expenses. This 'factored' rate is the amount charged per $100 of payroll.

CLASSIFICATIONS:

There are approximately 500 different workers compensation classifications, each of which individually describes a particular occupation.

Generally each employer will be entitled to the ONE basic classification which most accurately describes its operations. In addition, when that one basic classification does not specifically include one of the "Standard Exception" classifications (Clerical, Outside Salespersons, or Drivers), each employer may also be entitled to three additional classifications: Code 7380 - Drivers, Chauffeurs & Helpers; Code 8742 - Salespersons, Collectors or Messengers - Outside; and Code 8810 - Clerical Office Employees. Your insurance carrier will advise you of the classifications applicable to your operations.

However, when an employer is engaged in Construction, Erection, Stevedoring, Aircraft Operations (Industrial Aid), or Trucking as a secondary business, additional classifications may be assigned. Again, your carrier will counsel you on the classifications applicable to your operations.

DIVISION OF INDIVIDUAL EMPLOYEE'S PAYROLL

When any employee performs different duties which, if performed by a different worker, would qualify for a different classification assignment, you may divide that persons payroll between two or more classifications, PROVIDED separate verifiable payroll records are adequately maintained. When verifiable payroll records are not maintained, that individual's payroll must be assigned to the highest rated classification for any of the duties performed.

DATE OF ISSUE: **06-25-15**

VERIFIABLE RECORDS

Verifiable records are documents completed by an employee or supervisor every time the employee changes duties. These records should display the starting time and ending time for each type of work. Each block of time should note the duties the employee performed during that particular time period. Estimates or percentages of time spent in the different duties are not acceptable as verifiable records.

REMUNERATION - PAYROLL

"Payroll" means the TOTAL remuneration paid or payable by the employer for the services of the employees covered by the policy. Payroll INCLUDES commissions, anticipated bonuses, straight hourly wage for all hours worked, holiday pay, sick pay, piecework pay, tool allowances, value of living quarters provided by the employer, value of meals provided, value of store certificates or merchandise provided, and credits or any other substitute for money received by employees. Payroll does NOT INCLUDE profit-sharing amounts, unanticipated bonuses, vacation pay, tips or other gratuities received by employees from others, payments by the employer to group insurance or group pension plans, value of special rewards for individual invention or discovery, the value of a company-provided vehicle which is used in the employer's business or dismissal or severance payments except for the pay earned for the time worked. It also excludes payments from a program to reward workers for safe working practices.

SUBCONTRACTORS

When you subcontract a portion (or all) of your work to others and retain the right to exercise any direction and control (regardless of whether that right is exercised), you will be expected to pay the premiums for that subcontracted payroll UNLESS the subcontractor has its own workers compensation insurance coverage. In order to avoid the payment of premium for your subcontractors, you should obtain a CERTIFICATE OF INSURANCE from each subcontractor. At the time of audit, your insurance carrier will ask for any certificates of insurance and will exclude the subcontractor's payroll when the certificate is available.

EXPERIENCE RATING

When an employer's initial policy develops annual premium in excess of $5,000, the employer will qualify for experience rating at the beginning of the THIRD year and annually thereafter. When the employer develops premium in excess of $2,500 (but less than $5,000), they will qualify for an experience rating modification at the beginning of the FOURTH year. However, major changes in ownership may affect the continuation of individual employer data which may be used for experience rating purposes.

Essentially, the Experience Rating Program will use your company’s payroll, by individual classification, to determine the AVERAGE amount of losses expected to emerge from that payroll. It will then compare those EXPECT LOSSES to the ACTUAL LOSSES which were paid and/or reserved for any injuries occurring during the period covered by the data used in the annual experience rating process. When your company has BETTER than average experience, the experience modification will result in a CREDIT (reduction in our final premium), but if your experience is WORSE than average, a DEBIT (surcharge) will apply.

MERIT RATING

When an employer is too small to qualify for experience rating, a MERIT RATING program will apply. In general, this program will: a) reduce your final premium if there were no payments for "lost-time" injuries during the most recent year for which data has been compiled; b) will not affect your premium when there was only ONE lost-time injury; and c) will surcharge your premium when there are two or more lost-time injuries. Oregon law provided that, with the approval of regulatory authorities, insurance carriers may use their own customized merit rating plan. Maximum credits or surcharges are 10 percent. Check with your insurance carrier or agent for specific information about merit rating plans in effect in Oregon.

FEDERAL COVERAGES

While most employees will be subject to only the Oregon Workers Compensation Act, others MAY be subject to the Admiralty Act (for Masters or Members of a Vessel), to the Federal Employers Liability Act (Railroads engaged in Interstate Commerce), or the Longshore and Harborworkers Compensation Act (for stevedoring operations, building or repairing of vessels, new construction work in connection with marinas, etc.). However, the determination of exposures under any of the Federal Acts is a legal question which should be discussed with your insurance carrier or agent.

FINAL PREMIUM

When you obtain a policy from your insurance carrier, the premium will be ESTIMATED from the description of work and payroll information supplied by you. Your insurance carrier may either make interim audits or audit your account when your policy has expired. At that time, your final premium will be based upon the ACTUAL payrolls.

OREGON CLASSIFICATION AND RATING COMMITTEE

A Committee, composed of members well-versed in workers compensation insurance matters, meets periodically to hear the grievances of employers who feel they have been treated improperly in the assignment of classifications, payroll assignments, or experience ratings. (Since the 'rate' is an actuarial product which has been reviewed by the Insurance Department prior to approval for use, the appeal may NOT be based upon the rate or an individual classification. Should you feel you have been aggrieved, you may direct your specific allegations to the NCCI -Northwestern Service Office, One S.W. Columbia Blvd. (Suite 850) Portland, OR 97258 or contact your carrier for further information.

CONCLUSION

The above information has been designed to provide you with a broad overview of the Oregon Workers Compensation Insurance system. Should you have further questions, please contact your carrier or the NCCI Northwestern Service Office at the address indicated above.

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

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

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.

DATE OF ISSUE: **06-25-15**

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: _____

TRAVELERS

PENNSYLVANIA
POSTING NOTICE
RIGHTS AND DUTIES

Dear Policyholder:

On August 23, 1996 the State of Pennsylvania enacted broadening legislative changes pertaining to the rights and duties of employers and employees which requires you, the employer, to inform your employees of their rights under the Workers' Compensation And Employers' Liability Act, as well as your responsibilities as an employer. With the enacted legislation two major changes affecting both employer and employees should be noted.

1. Gives the employee the option of having a second opinion paid by the employer, before undergoing invasive surgery; and
2. Employer-controlled medical treatment has been expanded from 30 days to 90 days.

Enclosed is a new Posting Notice which must be posted in a conspicuous place where employees will readily see it. Also enclosed is a listing of physicians ("Pennsylvania Work-Related Injuries") which must be posted alongside the Posting Notice. It is your responsibility to complete this list of qualified physicians. Contact your Travelers claim representative or the nearest Travelers claim office for assistance in completing the list of physicians. Refer to the Posting Notice for the address of the nearest Travelers claim office.

The law also requires you to see that the "Rights and Duties" form is provided to each employee AND signed by each employee, and that a record is maintained for future reference. It is your responsibility to photocopy the form and distribute it to each employee. If you fail to have this form distributed and signed by your employees, you may be liable for any treatment rendered for work-related injuries. With the legislative changes that have occurred it is necessary to update your records and have your employees sign the revised "Pennsylvania Rights and Duties" form.

Your agent, producer, or local claim office can assist you to be in compliance with the Pennsylvania Workers' Compensation Law.

TRAVELERS

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Your agent, producer, or local claim office can assist you to be in compliance with the Pennsylvania Workers' Compensation Law.

STATE OF ALABAMA
WORKERS' COMPENSATION INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER **THE TRAVELERS INSURANCE COMPANIES**

TELEPHONE NUMBER **1-800-238-6225**

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

STATE OF ALABAMA
WORKERS' COMPENSATION INFORMATION

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CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

TO BE POSTED BY EMPLOYER POLICY NUMBER **(HJUB-6E20721-A-15)**

ISSUED TO: **BC TECHNICAL, INC.**

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: **THE TRAVELERS INSURANCE COMPANIES .**

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

*** * * * * * * * * * * * * * ***

PARA SER COLOCADO POR EL PATRON NUMERO DE POLIZA **(HJUB-6E20721-A-15)**

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACIÓN PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Título 23, Capítulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensación por medio de:
THE TRAVELERS INSURANCE COMPANIES

Además, a todos los empleados se les notifica por este medio que en caso de que específicamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

*** * * * * * * * * * * * * * ***

KEEP POSTED IN A CONSPICUOUS PLACE.
COLOQUESE EN LUGAR VISIBLE.

TO BE POSTED BY EMPLOYER POLICY NUMBER **(HJUB-6E20721-A-15)**

ISSUED TO: **BC TECHNICAL, INC.**

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*** * * * * * * * * * * * * * ***

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AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACIÓN PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Título 23, Capítulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensación por medio de:
THE TRAVELERS INSURANCE COMPANIES

Además, a todos los empleados se les notifica por este medio que en caso de que específicamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

*** * * * * * * * * * * * * * ***

KEEP POSTED IN A CONSPICUOUS PLACE.
COLOQUESE EN LUGAR VISIBLE.

TO BE POSTED BY EMPLOYER POLICY NUMBER **(HJUB-6E20721-A-15)**

ISSUED TO: **BC TECHNICAL, INC.**

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: **THE TRAVELERS INSURANCE COMPANIES .**

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

*** * * * * * * * * * * * * * ***

PARA SER COLOCADO POR EL PATRON NUMERO DE POLIZA **(HJUB-6E20721-A-15)**

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ISSUED TO: BC TECHNICAL, INC.

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

Notice to Employees – Injuries Caused By Work

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- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if your injury arises on or after 1/1/04 and results in a permanent disability that prevents you from returning to work within 60 days after TD ends, and your employer does not offer you modified or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

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Current MPN's toll free number: **(800) 287-9682** MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date_____ Current MPN's address: **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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.

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TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator _____

Phone **1-800-238-6225**

Workers' compensation insurer _____ (Enter "self-insured" if appropriate)

Policy Expiration Date **06-06-16**

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DWC 7 (6/10)
W04P2H10

ISSUED TO: BC TECHNICAL, INC.

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

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Policy Expiration Date **06-06-16**

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DWC 7 (6/10)
W04P2H10

ISSUED TO: BC TECHNICAL, INC.

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

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DWC 7 (6/10)
W04P2H10

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DWC 7 (6/10)
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participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

DWC 7 (6/10)
W04P2H10

ISSUED TO: BC TECHNICAL, INC.

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

Notice to Employees – Injuries Caused By Work

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DWC 7 (6/10)
W04P2H10

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Division of Workers' Compensation

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DWC 7 (6/10)
W04P2H10

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

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DWC 7 (6/10)
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3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you predesignated by naming your personal physician or medical group before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Different rules apply if your employer offers a Health Care Organization (HCO) or has a Medical Provider Network (MPN). You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
4. **Medical Provider Networks.** Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If your employer is using a MPN, a MPN notice should be posted next to this poster to explain how to use the MPN. You can request a copy of this notice by calling the MPN number below**. If you have predesignated a personal physician prior to your work injury, then you may receive treatment from your predesignated doctor.** If you have not predesignated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer. 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:

Current MPN's toll free number: **(800) 287-9682** MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date_____ Current MPN's address: **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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):

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator _____

Phone **1-800-238-6225**

Workers' compensation insurer _____ (Enter "self-insured" if appropriate)

Policy Expiration Date **06-06-16**

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement (DLSE).

You can also get free information from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401.** Learn more information about DWC and DLSE online: **www.dwc.ca.gov or www.dir.ca.gov/dlse.**

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.

DWC 7 (6/10)
W04P2H10

ISSUED TO: BC TECHNICAL, INC.

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

Notice to Employees – Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. There is a limit on some medical services.
- **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 your injury causes a permanent disability.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if your injury arises on or after 1/1/04 and results in a permanent disability that prevents you from returning to work within 60 days after TD ends, and your employer does not offer you 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 and your physician must agree to treat you for your work injury. For instructions, 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 your injury. Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for your alleged injury and shall be liable for up to ten thousand dollars ($10,000) in treatment 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 by naming your personal physician or medical group before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Different rules apply if your employer offers a Health Care Organization (HCO) or has a Medical Provider Network (MPN). 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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Current MPN's toll free number: **(800) 287-9682** MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date_____ Current MPN's address: **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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):

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator _____

Phone **1-800-238-6225**

Workers' compensation insurer _____ (Enter "self-insured" if appropriate)

Policy Expiration Date **06-06-16**

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement (DLSE).

You can also get free information from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401.** Learn more information about DWC and DLSE online: **www.dwc.ca.gov or www.dir.ca.gov/dlse.**

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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.

DWC 7 (6/10)
W04P2H10

ISSUED TO: BC TECHNICAL, INC.

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 de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiograf as y medicinas que son razonablemente necesarias para tratar su lesón. 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 su lesión le causa una incapacidad permanente.
- **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 impida 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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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 o departamento de policía. 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 autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dolares ($10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (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 antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puederecibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico 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 siguente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN _____ Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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 establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. 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 **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. 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 de la DWC y DLSE en el Internet en: **www.dwc.ca.gov o www.dir.ca.gov/dlse.**

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.

ISSUED TO: BC TECHNICAL, INC.

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 de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiograf as y medicinas que son razonablemente necesarias para tratar su lesón. 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 su lesión le causa una incapacidad permanente.
- **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 impida 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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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 o departamento de policía. 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 autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dolares ($10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (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 antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Fecha de vigencia de la MPN _____ Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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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 contratado. 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 **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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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.

ISSUED TO: BC TECHNICAL, INC.

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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- **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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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.

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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 autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dolares ($10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (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 antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN _____ Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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 establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. 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 **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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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.

ISSUED TO: BC TECHNICAL, INC.

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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- **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 impida 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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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.

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Teléfono **1-800-238-6225**

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Fecha de Vencimiento de la Póliza **06-06-16**

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
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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 contratado. 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 **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. 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 de la DWC y DLSE en el Internet en: **www.dwc.ca.gov o www.dir.ca.gov/dlse.**

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.

ISSUED TO: BC TECHNICAL, INC.

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 de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiograf as y medicinas que son razonablemente necesarias para tratar su lesón. 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 su lesión le causa una incapacidad permanente.
- **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 impida 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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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.

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3. **Consulte al Médico que le está Atendiendo (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 antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: **WWW.MYWCINFO.COM**

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Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

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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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Fecha de Vencimiento de la Póliza **06-06-16**

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
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- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **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 impida 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 medico personal o grupo médico, *antes* de que usted se lesione y su médico debe estar de acuerdo de atenderle 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.

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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 autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dolares ($10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (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 antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN _____ Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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 establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. 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 **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. 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 de la DWC y DLSE en el Internet en: **www.dwc.ca.gov o www.dir.ca.gov/dlse.**

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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.

ISSUED TO: BC TECHNICAL, INC.

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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Fecha de vigencia de la MPN _____ Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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Administrador de Reclamos **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

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ISSUED TO: BC TECHNICAL, INC.

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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Administrador de Reclamos **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono **1-800-238-6225**

Asegurador del Seguro de Compensación de trabajador _____(Anote "autoasegurado" si es apropiado)

Fecha de Vencimiento de la Póliza **06-06-16**

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COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

THE TRAVELERS INSURANCE COMPANIES

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 visit our website at: www.coworkforce.com/dwc/.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH Street, Suite 400, Denver, CO 80202-3660

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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 visit our website at: www.coworkforce.com/dwc/.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH Street, Suite 400, Denver, CO 80202-3660

Any information provided below comes from your employer and is specific to this place of employment:

State of Connecticut Worker's Compensation Commission

Notice to Employees

Workers' Compensation Act

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

BC TECHNICAL, INC.

10 HOLLY DR
E HAMPTON CT 06424

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

Section 31-294b of 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." Such an injury report by the employee is NOT an official written notice of claim for workers' compensation benefits. (The Form 30C is necessary to satisfy this requirement.)

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 5008 **Telephone** (800) 238-6225

City/Town HARTFORD **State** CT **Zip Code** 06102-5008

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

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

Address 90 COURT STREET **Telephone** (860) 344-7453

City/Town MIDDLETOWN **State** CT **Zip Code** 06457

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).

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A 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 _____

Rev. 8-31-2004

W06P1V09

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City/Town HARTFORD **State** CT **Zip Code** 06102-5008

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

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

Address 700 STATE STREET **Telephone** (203) 789-7512

City/Town NEW HAVEN **State** CT **Zip Code** 06511-6500

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Date Posted _____

Rev. 8-31-2004

W06P1V09

ISSUED TO: **BC TECHNICAL, INC.** **6E20721A**

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injures and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including, an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

name/address/phone	name/address/phone	name/address/phone
name/address/phone	name/address/phone	name/address/phone

(Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers' Compensation Law is:

THE TRAVELERS INSURANCE COMPANIES
Name

CALLER SERVICE #1818
ALPHARETTA, GA 30023-1818 **1-800-238-6225**
address phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalities of up to $10,000.00 per violation (O.C.G. A. § 34-9-18 and § 34-9-19)

WC-P1 (7/2006)

W10P1P10

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WC-P1 (7/2006)

W10P1P10

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $525 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $525 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $350 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $350 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $525 per week. A widowed spouse with no children will be paid a maximum of $150,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
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8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777.

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WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 d as consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $525 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no mas de $525 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $350 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no mas de $350 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $525 por semana. Una esposa viuda sin niños se le pagara un máximo de $150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compa a de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compa a de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año despuès de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del diá que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: http://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777.

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CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA $10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

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10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del diá que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: http://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: http://www.sbwc.georgia.gov
CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA $10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

ISSUED TO: **BC TECHNICAL, INC.** **6E20721A**

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

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Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 dias (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de Ia Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de Ia lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clinicas indústriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea Ia regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un tambio de un doctor a otro en Ia lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de Ia Junta Estatal de Compensación de Trabajadores.

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270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
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(Médicos adicionales pueden ser agregados en una hoja separada.)
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THE TRAVELERS INSURANCE COMPANIES
Nombre

CALLER SERVICE #1818
ALPHARETTA, GA 30023-1818 **1-800-238-6225**
dirección teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: http://www.sbwc.georgia.gov

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WC-P1 (7/2006)

W10P4P10

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WC-P1 (7/2006)

W10P4P10

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WC-P1 (7/2006)

W10P4P10

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.
2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims **FARMINGTON CASUALTY COMPANY**			
Business address	**P.O. BOX 3205** **NAPERVILLE, IL 60566-7205**		
Business phone	**(800) 238-6225**		
Effective date	**06-06-15**	Termination date	**06-06-16**
Policy number	**(HJUB-6E20721-A-15)**	Employer's FEIN	**870550892**

ICPN 10/11 *Printed by the authority of the State of Illinois.*

W12P1O12

WORKERS' COMPENSATION

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Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims **FARMINGTON CASUALTY COMPANY**			
Business address	**P.O. BOX 3205** **NAPERVILLE, IL 60566-7205**		
Business phone	**(800) 238-6225**		
Effective date	**06-06-15**	Termination date	**06-06-16**
Policy number	**(HJUB-6E20721-A-15)**	Employer's FEIN	**870550892**

ICPN 10/11 *Printed by the authority of the State of Illinois.*

W12P1O12

COMPENSACION A LOS TRABAJADORES

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2. **NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
3. **CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

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Dirección de la Compañía:	**P.O. BOX 3205** **NAPERVILLE, IL 60566-7205**		
Teléfono de la Compañía:	**(800) 238-6225**		
Fecha efectiva:	**06-06-15**	Fecha de terminación:	**06-06-16**
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Issued To: **BC TECHNICAL, INC.**

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Your employer is required to provide for payment of benefits under the Workers' Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The Workers' Compensation insurance carrier or the administrator for

BC TECHNICAL, INC.
(name of company)

is: THE TRAVELERS INSURANCE COMPANIES
(name of insurance carrier or administrator)

(name of carrier/administrator)

P.O. BOX 50472
(mailing address)

INDIANAPOLIS, IN 46250-0472
(city, state, zip)

1-800-238-6225
(telephone number)

WC Supervisor
(contact person)

For more information about rights or procedures under the Indiana Workers' Compensation system, call or write:

Workers' Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

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Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The Workers' Compensation insurance carrier or the administrator for

BC TECHNICAL, INC.
(name of company)

is: THE TRAVELERS INSURANCE COMPANIES
(name of insurance carrier or administrator)

(name of carrier/administrator)

P.O. BOX 50472
(mailing address)

INDIANAPOLIS, IN 46250-0472
(city, state, zip)

1-800-238-6225
(telephone number)

WC Supervisor
(contact person)

For more information about rights or procedures under the Indiana Workers' Compensation system, call or write:

Workers' Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

Issued To: **BC TECHNICAL, INC.**

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía

BC TECHNICAL, INC.
(nombre de la compañía)

es:

THE TRAVELERS INSURANCE COMPANIES
(nombre de la compañía de seguro/administrador)

P.O. BOX 50472
(dirección)

INDIANAPOLIS, IN 46250-0472
(ciudad, estado, código postal)

1-800-238-6225
(número de teléfono)

WC Supervisor
(persona de contacto)

Para más información acerca de sus derechos o loss procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Workers' Compensation Board of Indiana
Ombudsman Division
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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.

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

THE TRAVELERS INSURANCE COMPANIES (_____) **(800) 238-6225**

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

PO BOX 2928
OVERLAND PARK, KS 66201-1328

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

Web site: www.dol.ks.gov/workcomp/default.aspx
E-mail: wc@dol.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.

BC TECHNICAL, INC.

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

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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.

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

THE TRAVELERS INSURANCE COMPANIES (_____) **(800) 238-6225**

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PO BOX 2928
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KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 2-14)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) **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.

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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.

(2) **FOLLOW YOUR EMPLOYER'S INSTRUCTIONS** for getting medical aid and follow the doctor's instructions.

(3) **MEDICAL BENEFITS:** An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) **WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program.** Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. 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 the Technology and Statistics section of the 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.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

Address PO BOX 2928
OVERLAND PARK, KS 66201-1328

Contact Person _____

Phone (_____) (800) 238-6225

Email _____

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

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Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) **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.

(2) **FOLLOW YOUR EMPLOYER'S INSTRUCTIONS** for getting medical aid and follow the doctor's instructions.

(3) **MEDICAL BENEFITS:** An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) **WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program.** Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. 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 the Technology and Statistics section of the 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.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

Address PO BOX 2928
OVERLAND PARK, KS 66201-1328

Contact Person _____

Phone (_____) (800) 238-6225

Email _____

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 2-14)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

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Company THE TRAVELERS INSURANCE COMPANIES

Address PO BOX 2928
OVERLAND PARK, KS 66201-1328

Contact Person _____

Phone (_____) (800) 238-6225

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 2-14)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible**.

(1) **NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE**: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador 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.

(2) **SIGA LAS INSTUCCIONES DE SU EMPLEADOR** para conseguir ayuda médica y siga las instrucciones del doctor.

(3) **BENEFICIOS MÉDICOS:** El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) **BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.

Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.

Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto- asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.

2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.

3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.

4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.

5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

Dirección PO BOX 2928
OVERLAND PARK, KS 66201-1328

Persona de Contacto _____

Teléfono (_____) (800) 238-6225

Correo electrónico _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 2-14)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

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(2) **SIGA LAS INSTUCCIONES DE SU EMPLEADOR** para conseguir ayuda médica y siga las instrucciones del doctor.

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(4) **BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

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SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

Dirección PO BOX 2928
OVERLAND PARK, KS 66201-1328

Persona de Contacto _____

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K-WC 270-A (Revisado 2-14)

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SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

Dirección PO BOX 2928
OVERLAND PARK, KS 66201-1328

Persona de Contacto _____

Teléfono (_____) (800) 238-6225

Correo electrónico _____

COMMONWEALTH OF KENTUCKY

WORKERS COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: **BC TECHNICAL, INC.**
Address: **7172 S AIRPORT RD**
WEST JORDAN UT 84084

Workers Compensation Carrier
(or third party administrator): **THE TRAVELERS INSURANCE COMPANIES**

Policy #: **(HJUB-6E20721-A-15)** , effective **06-06-15** to **06-06-16**

Address: **P.O. BOX 50472**
INDIANAPOLIS IN 46250-0472

Telephone: **1-800-238-6225** , Contact Person **CLAIM MANAGER**

EMPLOYEES: If INJURED - NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____ , phone number _____.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Department of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The Kentucky Department of Workers Claims at 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS - NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

W16P1P07

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 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

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 61124
NEW ORLEANS, LA 70161-1124
(800) 238-6225

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

Employer Representative

_____

_____

_____

_____

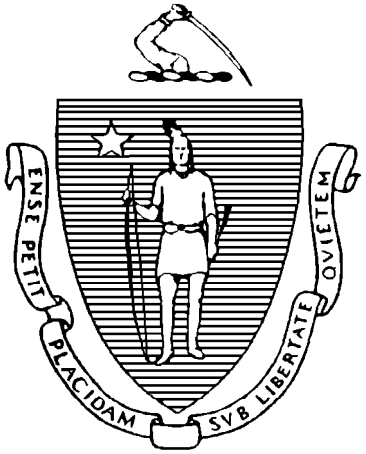
Employer

BC TECHNICAL, INC.
7172 S AIRPORT RD
WEST JORDAN UT 84084

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 05-03

LOUISIANA WORKS™
DEPARTMENT OF LABOR
www.LAWORKS.net

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111

617–727–4900 — http://www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above mentioned chapter by insuring with:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

P.O. BOX 1450
MIDDLEBORO, MA 02344-1450

ADDRESS OF INSURANCE COMPANY

(HJUB-6E20721-A-15) **06-06-15** TO **06-06-16**

POLICY NUMBER EFFECTIVE DATES

LOCKTON COMPANIES LLC **444 W 47TH ST STE 900**

KANSAS CITY **MO 64112**

NAME OF INSURANCE AGENT ADDRESS PHONE #

BC TECHNICAL, INC. **NO BUSINESS LOCATION**

NONE
MA 02101

EMPLOYER ADDRESS

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

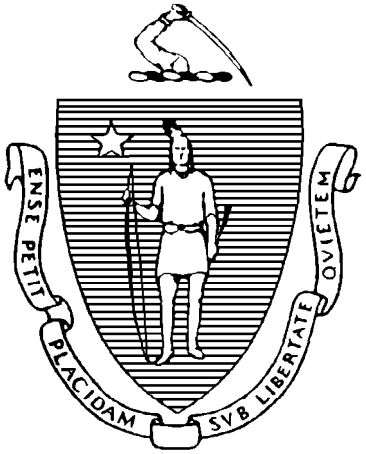
The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

W20P1G02

NOTICE TO EMPLOYEES



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LOCKTON COMPANIES LLC **444 W 47TH ST STE 900**

KANSAS CITY **MO 64112**

NAME OF INSURANCE AGENT ADDRESS PHONE #

BC TECHNICAL, INC. **6 PRINCESS PINE LANE**

MILFORD
MA 01757

EMPLOYER ADDRESS

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

W20P1G02

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. If you have reason to suspect someone is committing workers' compensation fraud, call 1-888-FRAUD MN (1-888-372-8366).

For more information about workers' compensation or if you need assistance with a claim, contact:

Department of Labor and Industry
Workers' Compensation
443 Lafayette Road N.
St. Paul, MN 55155

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

Insurer name

THE TRAVELERS INSURANCE COMPANIES

1-800-238-6225
Phone number

Posting required by law in a conspicuous location wherever the employer is engaged in business.

This material can be provided to you in different formats (Braille, large print or audio) if you call (651) 284-5005; toll-free at 1-800-DIAL-DLI (1-800-342-5354); or via TTY at (651) 297-4198. April 2012

Workers' compensation

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- 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.
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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 podría 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, por sus siglas en inglés), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notifcarle por escrito si tiene cobertura con una 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 notifcación por escrito cuando solicite la información.

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

– Pagos por compensación laboral –

- Atención médica razonable y necesaria para su lesión ocurrida en el trabajo.
- Benefcios 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 una demanda 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 consecutivos:** La aseguradora le notificará y debera 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 consecutivos:** La aseguradora le enviará una notifcación 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 la unidad de Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al teléfono gratuito 1-800-342-5354.**

Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Si tiene motivos para sospechar que alguien está cometiendo fraude con el programa de compensación laboral, llame al 1-888-FRAUD MN (1-888-372-8366).

Para obtener información adicional sobre compensación laboral o si necesita ayuda con un reclamo, comuníquese con el:

Department of Labor and Industry
Workers' Compensation
443 Lafayette Road N.
St. Paul, MN 55155

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

Nombre de la compañía aseguradora

THE TRAVELERS INSURANCE C OMPANIES

1-800-238-6225
Número de teléfono

Por ley, esta información se debe colocar en un lugar visible en todas las áreas en las que la empresa hace negocios.

Este material está disponible en diferentes formatos (Braille, letra de imprenta grande o audio) si llama al (651) 284-5005; llamada gratuita al 1-800-DIAL-DLI (1-800-342-5354) o v a TTY (retransmisi n) al (51)297-4198. Abril de 2012

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- 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 notifcación por escrito cuando solicite la información.

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- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
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Nombre de la compañía aseguradora

THE TRAVELERS INSURANCE C OMPANIES

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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 **THE TRAVELERS INSURANCE COMPANIES**
Address **P.O.BOX 66852 ST. LOUIS, MO 63166-6852**
Phone **(800) 238-6225**

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

1. 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.

Missouri Division of Workers', Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities

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

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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.

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

DIVISION OF WORKERS' COMPENSATION

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

Name **THE TRAVELERS INSURANCE COMPANIES**
Address **P.O.BOX 2928 (WC) OVERLAND PARK, KS 66201-9833**
Phone **(800) 238-6225**

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

1. 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.

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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.

Missouri Division of Workers', Compensation is an equal opportunity employer/program.
Auxiliary aids and services are available upon request to individuals with disabilities

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.

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Address **P.O.BOX 66852 ST. LOUIS, MO 63166-6852**
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Compañía de seguros,Adminstrador independiente, Compañía de servicios o Persona designada si tiene seguro propio

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Dirección **P.O.BOX 66852 ST. LOUIS, MO 63166-6852**

Teléfono **(800) 238-6225**

INFORMACIÓN PARA EL EMPLEADO

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Pasos a tomar si se lesiona en el trabajo

1. Notifique inmediatamente a su empleador (debe presentarse un aviso par 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.

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Beneficios para empleados lesionados

Cuidado médica:

El empleador o asegurador tiene que proporcionar tratamiento y cuidado médico para curar y aliviar los efectos de la lesión. Esto incluye todos los costas del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. No hay deducibles y todos los costas los paga el empleador o su compañía de seguro de compensación a los trabajadores. Si usted recibe una factura, **comuniquese 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 hacer, puede ser por su propia cuenta.

Pago de salarios perclidos:

- 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 mejoria médica", lo que ocurra primero.
- Si usted regresa a trabajar en labores ligeras o modilicadas por menos del salario completo, puede que tenga derecho a recibir beneficios par **incapacidad parcial temporal**.

Beneficios por incapacidad permanente:

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

Beneficios de sobreviviente:

Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficos par 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.

La División de Compensación a los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades. Hay recursos y servicios disponibles para personas discapacitadas si se solicitan.

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 ellugar de trabajo de manera que los empleados lo vean. Este póster es obligatorio conforme ala sección 287.127, Estatutos Revisados de Missouri, y está disponible para empleadores y aseguradores sin costa 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 sabre la lesión ala campañía de seguros o Administrador externo (TPA) dentro de un plaza de cinco dias a partir de la fecha de la lesión o de la fecha en que el empleado informó al empleador sabre 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 dias 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 costas 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 llama al 573-751-4231 para obtener más información sabre estos programas o un registro de consultores independientes que están certificados en el estado de Missouri para proporcionar asistencia en seguridad.

Fraude/Falte 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 legitima, 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 S10,000. 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 cualla compafiia 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 infraccion 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 annual que el empleador habria 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 anuncia 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.

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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).**
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Beneficios de sobreviviente:

Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficos par 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.

La División de Compensación a los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas si se solicitan.

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 ellugar de trabajo de manera que los empleados lo vean. Este póster es obligatorio conforme ala sección 287.127, Estatutos Revisados de Missouri, y está disponible para empleadores y aseguradores sin costa 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 sabre la lesión ala campañía de seguros o Administrador externo (TPA) dentro de un plaza de cinco dias a partir de la fecha de la lesión o de la fecha en que el empleado informó al empleador sabre 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 dias 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 costas 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 llama al 573-751-4231 para obtener más información sabre estos programas o un registro de consultores independientes que están certificados en el estado de Missouri para proporcionar asistencia en seguridad.

Fraude/Falte 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 legitima, 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 S10,000. 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 cualla compafiia 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 infraccion 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 annual que el empleador habria 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 anuncia 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.

DIVISION OF WORKERS' COMPENSATION

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

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

Nombre **THE TRAVELERS INSURANCE COMPANIES**

Dirección **P.O.BOX 66852 ST. LOUIS, MO 63166-6852**

Teléfono **(800) 238-6225**

INFORMACIÓN PARA EL 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 la autoridad para aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada con el derecho de un empleado lesionado a los beneficios.

Pasos a tomar si se lesiona en el trabajo

1. Notifique inmediatamente a su empleador (debe presentarse un aviso par 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 empleados lesionados

Cuidado médica:

El empleador o asegurador tiene que proporcionar tratamiento y cuidado médico para curar y aliviar los efectos de la lesión. Esto incluye todos los costas del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. No hay deducibles y todos los costas los paga el empleador o su compañía de seguro de compensación a los trabajadores. Si usted recibe una factura, **comuniquese 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 hacer, puede ser por su propia cuenta.

Pago de salarios perclidos:

- 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 mejoria médica", lo que ocurra primero.
- Si usted regresa a trabajar en labores ligeras o modilicadas por menos del salario completo, puede que tenga derecho a recibir beneficios par **incapacidad parcial temporal**.

Beneficios por incapacidad permanente:

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

Beneficios de sobreviviente:

Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficos par 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.

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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 legitima, 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 S10,000. Una infracción subsiguiente es un delito grave de clase C.

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TRAVELERS

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **Insurance Company**

for the period

Beginning 06-06-15 **Ending** 06-06-16

Employer BC TECHNICAL, INC.

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

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TRAVELERS

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Compañia de Seguro

por el periodo

Comenzando 06-06-15 **Terminando** 06-06-16

Patron BC TECHNICAL, INC.

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

TRAVELERS

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El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

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STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 – 100 Broadway-Menands – (866) 750-5157
***Brooklyn, 11201 – 111 Livingston St. – Brooklyn – (800) 877-1373**
Binghamton, 13901 – State Office Bldg. – 44 Hawley St. – (866) 802-3604
Buffalo, 14202 – 295 Main Street, Suite 400 - (866) 211-0645
***Hauppauge, 11788 – 220 Rabro Drive – Suite 100 – (866) 681-5354**
***Hempstead, 11550 – 175 Fulton Avenue – (866) 805-3630**
***New York, 10027 – 215 W.125th St., Manhattan – (800)-877-1373**
***Peekskill, 10566 – 41 North Division St. (866) 746-0552**
***Queens, 11432 – 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 – 130 Main Street West – (866) 211-0644
Syracuse, 13203 – 935 James St. – (866) 802-3730

*** DOWNSTATE MAILING ADDRESS**

Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205**

AVISO DE CUMPLIMIENTO A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podria ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Statewide Fax: 877-533-0337

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

BC TECHNICAL, INC.

THE TRAVELERS INSURANCE COMPANIES
P.O.BOX 4614
BUFFALO, NY 14240-4614
1-800-238-6225

For Insurance Carriers ONLY: Policy No **6E20721A**
Policy in Force from **06-06-15** *to* **06-06-16**

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (1-11)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.state.ny.us

W31P1N11

STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 – 100 Broadway-Menands – (866) 750-5157
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*** DOWNSTATE MAILING ADDRESS**

Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205**

AVISO DE CUMPLIMIENTO A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podria ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
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Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Statewide Fax: 877-533-0337

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

BC TECHNICAL, INC.

THE TRAVELERS INSURANCE COMPANIES
P.O.BOX 8924 (WC)
MELVILLE, NY 11747-8924
1-800-238-6225

For Insurance Carriers ONLY: Policy No **6E20721A**
Policy in Force from **06-06-15** *to* **06-06-16**

Name of employer (Nombre del patrono)

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C-105 (1-11)

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W31P1N11

STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

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*** DOWNSTATE MAILING ADDRESS**

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For Insurance Carriers ONLY: Policy No **6E20721A**
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Name of employer (Nombre del patrono)

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STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

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Name of employer (Nombre del patrono)

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STATE OF NEW YORK – WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

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9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Statewide Fax: 877-533-0337

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

BC TECHNICAL, INC.

THE TRAVELERS INSURANCE COMPANIES
P.O.BOX 466 (WC)
ALBANY, NY 12201-0466
1-800-238-6225

For Insurance Carriers ONLY: Policy No **6E20721A**
Policy in Force from **06-06-15** *to* **06-06-16**

Name of employer (Nombre del patrono)

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (1-11)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.state.ny.us

W31P1N11

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).

2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)

3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.

4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.

5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.

6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.

7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)

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9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.

10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.

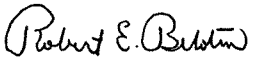
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

Insert name and address of insurance carrier.

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614



ROBERT E. BELOTEN
CHAIR

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC(800)877-1373/Hemp.(866)805-3630/Haup.(866)681-5354/Peek.(866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

C-430S (1-11) ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO *www.wcb.state.ny.us*

W31P5N11

DECLARACION DE DERECHOS

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACIONOBRERA
Robert E. Beloten, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).

2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)

3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.

4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.

5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.

6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.

7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya o no sufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico ó al hospital. (Obtenga recibos para justificar gastos.)

8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.

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10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comunicate con la oficina mas cercana de la Junta y solicita hablar con un trabajador social o con un consejero de rehabilitación.

11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

Insert name and address of insurance carrier.

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

Robert E. Beloten

ROBERT E. BELOTEN
PRESIDENTE

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C-430S (1-11)

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

www.wcb.state.ny.us
W31P5N11

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS

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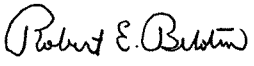
Insert name and address of insurance carrier.

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 8924 (WC)
MELVILLE, NY 11747-8924



ROBERT E. BELOTEN
CHAIR

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W31P5N11

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ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACIONOBRERA
Robert E. Beloten, Presidente

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3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.

4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.

5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.

6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.

7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)

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11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

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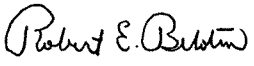
Insert name and address of insurance carrier.

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 8924 (WC)
MELVILLE, NY 11747-8924



ROBERT E. BELOTEN
CHAIR

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C-430S (1-11) ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO *www.wcb.state.ny.us*

W31P5N11

DECLARACION DE DERECHOS

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACIONOBRERA
Robert E. Beloten, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).

2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)

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4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.

5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.

6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.

7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya o no sufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico ó al hospital. (Obtenga recibos para justificar gastos.)

8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.

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11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

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Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

Insert name and address of insurance carrier.

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Robert E. Beloten

ROBERT E. BELOTEN
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C-430S (1-11)

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W31P5N11

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

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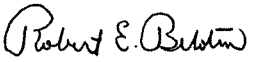

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W31P5N11

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ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACIONOBRERA
Robert E. Beloten, Presidente

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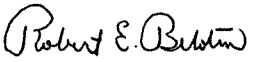

ROBERT E. BELOTEN
CHAIR

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC(800)877-1373/Hemp.(866)805-3630/Haup.(866)681-5354/Peek.(866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157	State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604	Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645	130 Main Street W. ROCHESTER 14614 (866) 211-0644	935 James St. SYRACUSE 13203 (866) 802-3730

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

C-430S (1-11) ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO *www.wcb.state.ny.us*

W31P5N11

DECLARACION DE DERECHOS

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACIONOBRERA
Robert E. Beloten, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).

2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)

3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.

4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.

5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.

6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.

7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya o no sufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico ó al hospital. (Obtenga recibos para justificar gastos.)

8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.

9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo ó por una enfermedad ocupacional ó por una lesión en el cumplimiento de su deber como bombero voluntario ó como miembro voluntario del cuerpo de ambulancia, usted puede tener derecho a recibir beneficios por incapacidad (para lesiones fuera del trabajo). Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuniquese con cualquier oficina de la Junta.

10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comunicate con la oficina mas cercana de la Junta y solicita hablar con un trabajador social o con un consejero de rehabilitación.

11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

Insert name and address of insurance carrier.

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 466 (WC)
ALBANY, NY 12201-0466

Robert E. Beloten

ROBERT E. BELOTEN
PRESIDENTE

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SYRACUSE 13203
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C-430S (1-11)

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

www.wcb.state.ny.us
W31P5N11

FORM 17 Revised 11/2014

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

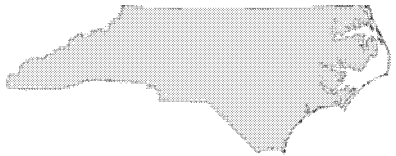
The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's workers' compensation insurance carrier is THE TRAVELERS INSURANCE COMPANIES.
- The insurance policy number is (HJUB-6E20721-A-15).
- Your employer's workers' compensation insurance policy is valid from 06-06-15 until 06-06-16.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.



For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov

NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

W32P1D15

FORM 17 Revised 11/2014

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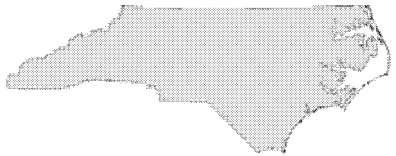

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W32P1D15

FORMA 17 Revisada 11/2014

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

- Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.
- Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.
- Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional.
- Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia.

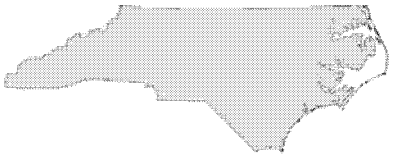
  Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.
- La compañía de seguros de compensación para trabajadores de su empleador es THE TRAVELERS INSURANCE COMPANIES.
- El número de la póliza de seguro es (HJUB-6E20721-A-15).
- La póliza de seguro de compensación para trabajadores de su empleador es válida desde 06-06-15 hasta 06-06-16.

Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA – (800) 688-8349.

El Empleador deberá:

- Proveer todos los servicios médicos necesarios al empleado.
- Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $2,000.00.
- Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.
- Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.

Para asistencia con entrenamiento de seguridad:
Director de Entrenamiento de Seguridad – (919) 807-2602 y safety@ic.nc.gov.



NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen. Stat. § 97-93).

W32P2D15

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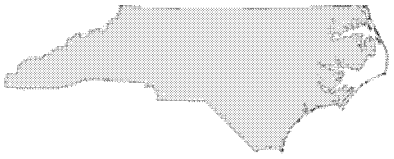

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W32P2D15

CC-Form-1A

Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees

All employees of this employer who are entitled to benefits of the Administrative Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Commission and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical, hospital, optometric, podiatric, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee, as well as payments of compensation to any injured employee or the employee's dependents as provided in the Act.

Any employee who has suffered a compensable injury covered by the Administrative Workers' Compensation Act is entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform work for which the person has previous training or experience.

The Oklahoma Workers' Compensation Commission has a Counselor Division to provide information to injured workers, employers, and other interested persons.

Mediation is available to help resolve certain workers' compensation disputes. For information, call the Counselor Division at 405-522-8760 or In-State Toll Toll Free 800-522-8210.

Signature of Employer

THE TRAVELERS INS COMPANIES, HARTFORD, CT 06183

Insurer Name and Address

06-06-16

Date of Expiration of Insurance Policy (Not applicable to employers authorized to self-insure)

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless oral or written notice is given to the employer within thirty (30) days, the claim for compensation may be forever barred.

The employee may file a claim for compensation with the **WORKERS' COMPENSATION COMMISSION** for an accidental injury, death, cumulative trauma or occupational disease or illness occurring **ON OR AFTER** February 1, 2014. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Commission. The forms are posted on the Commission's website, www.wcc.ok.gov.

A claim for compensation must be filed with the Commission within the time specified by law, or be forever barred. Based on law effective February 1, 2014, a claim for compensation for any accidental injury must be filed with the Commission within one (1) year of the date of injury; a death claim must be filed within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filed within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filed within one (1) year of the date of injury. A claim for additional compensation is barred unless filed within one (1) year of the last payment of disability compensation or two (2) years from the date of injury, whichever is longer.

Claims for compensation for accidental injury, death, cumulative trauma or occupational disease or illness occurring BEFORE February 1, 2014 may be filed with the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS and are subject to different notice of injury requirements and claims filing deadlines than those for accidental injury, death, cumulative trauma or occupational disease or illness occurring on or after February 1, 2014. Failure to comply with applicable notice requirements and deadlines may operate to forever bar the claim. Contact the Commission's Counselor Division for additional information.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical, surgical, hospital, optometric, podiatric, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. Within ten (10) days after the date of receipt of notice or knowledge of death or injury that results in more than three days' absence from work for the injured employee, the employer MUST send a report thereof to the Workers' Compensation Commission on a CC-Form 2, and also send a copy of the CC-Form 2 to the employer's insurance carrier, if any, within the ten-day period.

No agreement by any employee to pay any portion of the premium paid by the employer to a carrier or a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies as required by the workers' compensation laws, shall be valid. Any employer who makes a deduction for such purposes from the pay of any employee entitled to benefits under the workers' compensation laws shall be guilty of a misdemeanor.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tele. 405-522-8760 (OKC) 918-581-2714 (TU) In-State Toll Free 800-522-8210
Web Site www.wcc.ok.gov

Amended 6-19-2014

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

W35P1S15

CC-Form-1A

Aviso e Instrucción de Compensación de Trabajadores de Oklahoma para Empresarios y Trabajadores

Se notifica por la presente a todos los empleados de esta empresa que tengan derecho a los beneficios de la Ley de Compensación para Trabajadores Administrativos que este empleador ha cumplido con todas las reglas de la Comisión de Compensación de Trabajadores, y que este empleador ha asegurado el pago de compensación a todos los empleados y sus dependientes en conformidad con la ley. Asimismo, se notifica a todos los empleados que este empleador proporcionará primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología y enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con la lesión sufrida por el trabajador, así como los pagos de compensación a cualquier empleado lesionado o sus dependientes conforme a lo dispuesto por la ley.

Cualquier empleado que haya sufrido una lesión indemnizable amparado por la Ley de Compensación para Trabajadores Administrativos tiene derecho a los servicios de rehabilitación vocacional, esto incluye la re-capacitación e inserción laboral si el empleado ya no pudiese realizar el trabajo para el cual tuviese formación o experiencia previa como consecuencia de la lesión.

La Comisión de Compensación de Trabajadores de Oklahoma cuenta con una División de Asesoría para proporcionar información a los trabajadores lesionados, empleadores y otras personas interesadas.

Existe la posibilidad de mediación para ayudar a resolver disputas de compensación para ciertos trabajadores. Para obtener más información, llame a la División de Consejería al 405-522-8760 o al número gratuito (dentro del estado) 800-522-8210.

Firma del Empleador

THE TRAVELERS INS COMPANIES, HARTFORD, CT 06183

Nombre y Dirección del Asegurador

06-06-16

Fecha de Vencimiento de la Póliza de Seguro (No aplicable a los empleadores autorizados para auto-asegurarse.)

Responsabilidades del empleado en caso de sufrir una lesión relacionada trabajo

De resultar dañado o afectado por trauma acumulativo o una enfermedad profesional que surja del empleo y en el transcurso de su desempeño, por leve que sea, el empleado debe notificar al empleador inmediatamente. Si este empleador es una sociedad, se debe notificar a cualquier socio. Si este empleador es una corporación, la notificación se hará a cualquier agente o funcionario de la corporación autorizado a recibir tal notificación. Se notificará también a la persona a cargo de los negocios en el lugar de operaciones donde se haya producido la lesión. De no haber notificado verbalmente o por escrito al empleador dentro de los treinta (30) días, el reclamo de indemnización puede prescribir de forma definitiva.

El empleado puede presentar un reclamo de indemnización ante la **COMISIÓN DE COMPENSACIÓN DE TRABAJADORES** por una lesión accidental, muerte, trauma acumulativo o enfermedad profesional o enfermedad accidental que ocurra **EL** 1 de febrero de 2014, **O DESPUÉS** de esa fecha. Este empleador debe suministrar los formularios para presentar un reclamo de compensación, y también se encuentran disponibles en la Comisión de Compensación de Trabajadores. Los formularios se encuentran publicados en el sitio web de la Comisión, www.wcc.ok.gov.

El reclamo de compensación debe ser presentado ante la Comisión en el plazo fijado por la ley, o prescribirá para siempre. En virtud de la ley vigente a partir del 1 de febrero de 2014, los reclamos de indemnización por cualquier lesión accidental se deben presentar ante la Comisión dentro de un (1) año transcurrido a partir de la fecha de la lesión; debe presentarse un reclamo por muerte dentro de los dos (2) años de la fecha de muerte; los reclamos de indemnización por males o enfermedades profesionales se deben presentar dentro de los dos (2) años transcurridos a partir de la última exposición perjudicial; y los reclamos de indemnización por trauma acumulativo se deben presentar dentro de un (1) año transcurrido a partir de la fecha de la lesión. Se prohíben los reclamos de indemnización adicional a menos que sean presentados dentro de un (1) año transcurrido a partir del último pago de compensación por discapacidad o dos (2) años desde la fecha de la lesión, el período que sea mayor.

Los reclamos de indemnización por lesiones, muerte, trauma acumulativo o males o enfermedades profesional accidentales que ocurrieran ANTES del 1 de febrero de 2014 se pueden presentar ante el TRIBUNAL DE RECLAMOS EXISTENTES DE COMPENSACIÓN AL TRABAJADOR y estarán sujetos a diferentes requisitos de notificación de la lesión y distintos plazos para presentar reclamos a los requeridos para los correspondientes a lesiones accidentales, muerte, trauma acumulativo o males o enfermedades profesionales que ocurrieran a partir del 1 de febrero de 2014. El incumplimiento de los requisitos y los plazos de notificación aplicables puede resultar en la prescripción definitiva del reclamo. Póngase en contacto con la División de Asesoría de la Comisión para obtener información adicional.

Responsabilidades del Empleador

El empleador debe proporcionar a los empleados primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología, así como servicios de enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con la lesión sufrida por el empleado. Esto es aplicable al cuidado de todas las lesiones y enfermedades que surjan del empleo y el transcurso de su desempeño, independientemente de su carácter. El empleador DEBERÁ enviar, dentro de los diez (10) días a partir de la fecha de recepción de la notificación o el conocimiento de la muerte o lesión que resulte en más de tres días de ausencia del trabajo del empleado lesionado, un informe sobre esto a la Comisión de Compensación de Trabajadores en un formulario CC-Form 2, y también deberá enviar una copia de ese formulario a la compañía aseguradora del empleador, si la hubiere, en el plazo de diez días.

Se invalidará cualquier acuerdo hecho por un empleado para pagar cualquier porción de la prima pagada por el empleador a un operador, fondo de prestaciones o departamento mantenido por el empleador con el fin de indemnizar o proveer servicios y suministros médicos, tal como lo requieren las leyes de compensación de los trabajadores. Cualquier empleador que realice una deducción del pago de cualquier empleado con derecho a prestaciones en virtud de las leyes de compensación de los trabajadores para tales propósitos será culpable de un delito menor.

Se invalidará cualquier acuerdo hecho por un empleado para renunciar a los derechos y beneficios de compensación del trabajador.

Toda persona que cometa fraude de compensación del trabajador, será culpable, de ser condenada, de un delito grave punible con pena de prisión, una multa o ambas.

Comisión de Compensación de Trabajadores
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tel. 405-522-8760 (OKC) 918-581-2714 (TU) Línea gratuita (dentro del estado) 800-522-8210
Sitio Web www.wcc.ok.gov

Enmendado 6-19-14

Este aviso debe ser publicado y mantenido por el empleador en uno o más lugares visibles en el lugar de trabajo

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

REMEMBER:
It is Important to Tell Your Employer about Your Injury

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: BC TECHNICAL, INC. **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:
THE TRAVELERS INSURANCE COMPANIES

Address: P.O.BOX 13933 (WC)
READING, PA 19612-3933

Telephone Number: 1-800-238-6225

Insurer's Bureau Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number:

IF SELF-INSURED:
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number:

Self-Insured Bureau Code:

IF SOMEONE OTHER THAN SELF-INSURER HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

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Telephone Number:

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Telephone Number:

TENNESSEE WORKERS' COMPENSATION INSURANCE

Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees.
All employers engaged in the mining and production of coal with one (1) or more employees.
All workers in the construction industry unless they are specifically exempted.

To confirm if an employer is subject to the workers' compensation law and if so to obtain the name of the workers' compensation insurance company contact:

THE TRAVELERS INSURANCE COMPANIES

Name of employer representative authorized to provide information on workers' compensation

(800) 238-6225

Telephone number of employer representative to provide information on workers' compensation

P.O. BOX 682165
FRANKLIN, TN 37068-2165

Address of employer representative to provide information on workers' compensation

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required.
and **2.** Select a treating physician from a panel provided by the employer.
To report an injury contact:

Name of employer representative to notify in event of a work related injury

Telephone number of employer representative to notify in event of a work related injury

Address of employer representative to notify in event of a work related injury

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Dept. of Labor and Workforce Development, Workers' Compensation Division.
and **2.** Offer a panel of physicians.

The employer shall designate a group of three (3) or more physicians or surgeons not associated together in practice from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the panel shall be expanded to four (4), one of whom must be a doctor of chiropractic. If a doctor of chiropractic is chosen, chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The provisions for chiropractic care shall not apply to workers' compensation self insurer pools established pursuant to Section 50-6-405(a)(1). If the injury requires the treatment of physician or surgeon who practices orthopedic or neuroscience medicine then the employer may appoint a panel of physicians or surgeons practicing orthopedic or neuroscience medicine consisting of five (5) physicians, with no more than four (4) physicians affiliated in practice together. The employee may select a treating physician or surgeon from the employer panel.

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, has staff available to help both employees and employers. For more information contact:

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 OR TOLL FREE 1-800-332-2667 OR 1-800-332-2257 (TDD)
www.tn.gov/labor-wfd/wcomp.html

LB-0922 (REV. 03/12) RDA 10183

W41P1O12

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W41P1O12

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

Todo empleador que tenga cinco (5) o más de cinco empleados de horario completo o de medio horario.
Todo empleador que se dedique a la explotación de minas y la producción de carbón que tenga un (1) empleado o más de un empleado.
Todos los trabajadores de la industria de la construcción a menos que específicamente están exentos

Para comprobar si un empleador está sujeto a la ley de accidentes de trabajo y si ese fuera el caso, para obtener el nombre de la compañía de seguro de accidentes de trabajo a contactar:

THE TRAVELERS INSURANCE COMPANIES

Nombre del representante del empleador

(800) 238-6225

Número de teléfono del representante del empleador

P.O. BOX 682165
FRANKLIN, TN 37068-2165

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER UN EMPLEADO SI SE LESIONA EN EL TRABAJO?

1. Notificar al empleador de la lesión inmediatamente. Es obligatorio notificar al empleador.
y **2.** Escoger a un médico que le atienda de la lista que le dé el empleador.
Para notificar una lesión póngase en contacto con:

Nombre del representante del empleador

Número de teléfono del representante del empleador

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER EL EMPLEADOR CUANDO SE LE NOTIFICA DE UNA LESIÓN?

1. Llenar inmediatamente el formulario Primera Notificación de Accidente de Trabajo y enviarlo a la compañía deseguro de accidentes de trabajo o al administrador del seguro contra tercera persona para que lo registre en elDepartamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo.

y **2.** Ofrecer una lista de médicos.
El empleador deberá nombrar un grupo de tres (3) médicos o cirujanos o más que no estén afiliados a la misma oficina y de los cuales el empleado lesionado tendrá el privilegio de escoger ya sea el médico que le va a atender o el cirujano que le va a operar. Si la lesión es una lesión de la espalda, la lista aumentará a cuatro (4), entre los cuales habrá un médico quiropráctico. Si ud escoje un médico quiropráctico, las visitas pueden ser autorizadas hasta doce (12) vezes por la lesión de espalda. Si ud require más de doce (12) visitas al mismo médico quiropráctico tendra que tener autorización de su justador de seguransa or empleador. Las provisiones para el cuidado del quiropráctico no se aplicarán grupos de autoasegurador establecidas conforme a la Sección 50-6-405 (a) (1). Si es una lesión que requiere que le atienda un médico o cirujano que ejerce la medicina ortopédica o de neurociencias, entonces el empleador deberá nombrar un grupo de cinco (5) médicos o cirujanos que ejercen la medicina ortopédica o de neurociencias de entre los cuales sólo cuatro (4) pueden estar afiliados a la misma oficina. El empleado puede escoger un médico o cirujano de la lista del empleador para que le atienda.

El Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo tiene trabajadores disponibles para ayudar tanto al empleado como al empleador. Si necesita más información, favor de ponerse en contacto con:

DEPARTAMENTO DE TRABAJO Y DESARROLLO LABORAL DE TENNESSEE
DIVISIÓN DE ACCIDENTES DE TRABAJO
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 O LLAME GRATIS AL 1-800-332-2667 O AL 1-800-332-2257 (TDD)
www.tn.gov/labor-wfd/wcomp.html

LB-0922SP (REV. 03/12) RDA 10183

W41P2O12

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

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(800) 238-6225

Número de teléfono del representante del empleador

P.O. BOX 682165
FRANKLIN, TN 37068-2165

Dirección del representante del empleador

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www.tn.gov/labor-wfd/wcomp.html

LB-0922SP (REV. 03/12) RDA 10183

W41P2O12

SEGURO DE ACCIDENTES DE TRABAJO DE TENNESSEE

Empleadores: La ley exige que se ponga este aviso en un lugar del negocio del empleador bien visible para que todos los empleados tengan acceso al mismo.

¿QUIÉNES ESTÁN OBLIGADOS A TENER SEGURO DE ACCIDENTES DE TRABAJO?

Todo empleador que tenga cinco (5) o más de cinco empleados de horario completo o de medio horario.
Todo empleador que se dedique a la explotación de minas y la producción de carbón que tenga un (1) empleado o más de un empleado.
Todos los trabajadores de la industria de la construcción a menos que específicamente están exentos

Para comprobar si un empleador está sujeto a la ley de accidentes de trabajo y si ese fuera el caso, para obtener el nombre de la compañía de seguro de accidentes de trabajo a contactar:

THE TRAVELERS INSURANCE COMPANIES

Nombre del representante del empleador

(800) 238-6225

Número de teléfono del representante del empleador

P.O. BOX 682165
FRANKLIN, TN 37068-2165

Dirección del representante del empleador

(el nombre, la dirección y el número de teléfono del representante del empleador autorizado a dar información sobre indemnización por accidentes de trabajo)

¿QUÉ DEBE HACER UN EMPLEADO SI SE LESIONA EN EL TRABAJO?

1. Notificar al empleador de la lesión inmediatamente. Es obligatorio notificar al empleador.
y **2.** Escoger a un médico que le atienda de la lista que le dé el empleador.
Para notificar una lesión póngase en contacto con:

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¿QUÉ DEBE HACER EL EMPLEADOR CUANDO SE LE NOTIFICA DE UNA LESIÓN?

1. Llenar inmediatamente el formulario Primera Notificación de Accidente de Trabajo y enviarlo a la compañía deseguro de accidentes de trabajo o al administrador del seguro contra tercera persona para que lo registre en elDepartamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo.

y **2.** Ofrecer una lista de médicos.
El empleador deberá nombrar un grupo de tres (3) médicos o cirujanos o más que no estén afiliados a la misma oficina y de los cuales el empleado lesionado tendrá el privilegio de escoger ya sea el médico que le va a atender o el cirujano que le va a operar. Si la lesión es una lesión de la espalda, la lista aumentará a cuatro (4), entre los cuales habrá un médico quiropráctico. Si ud escoje un médico quiropráctico, las visitas pueden ser autorizadas hasta doce (12) vezes por la lesión de espalda. Si ud require más de doce (12) visitas al mismo médico quiropráctico tendra que tener autorización de su justador de seguransa or empleador. Las provisiones para el cuidado del quiropráctico no se aplicarán grupos de autoasegurador establecidas conforme a la Sección 50-6-405 (a) (1). Si es una lesión que requiere que le atienda un médico o cirujano que ejerce la medicina ortopédica o de neurociencias, entonces el empleador deberá nombrar un grupo de cinco (5) médicos o cirujanos que ejercen la medicina ortopédica o de neurociencias de entre los cuales sólo cuatro (4) pueden estar afiliados a la misma oficina. El empleado puede escoger un médico o cirujano de la lista del empleador para que le atienda.

El Departamento de Trabajo y Desarrollo Laboral de Tennessee, División de Accidentes de Trabajo tiene trabajadores disponibles para ayudar tanto al empleado como al empleador. Si necesita más información, favor de ponerse en contacto con:

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DIVISIÓN DE ACCIDENTES DE TRABAJO
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
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NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] BC TECHNICAL, INC. has workers' compensation insurance coverage from [Name of commercial insurance company]. THE TRAVELERS INSURANCE COMPANIES
In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 06-06-15 . Any injuries or occupational diseases which occur on or after that will be handled by [name of commercial insurance company]
THE TRAVELERS INSURANCE COMPANIES 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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THE TRAVELERS INSURANCE COMPANIES 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.

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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.

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] **BC TECHNICAL, INC.** tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] **THE TRAVELERS INSURANCE COMPANIES** para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] **06-06-15** . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy].
THE TRAVELERS INSURANCE COMPANIES

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

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EMPLEADOR CON COBERTURA

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] **BC TECHNICAL, INC.** tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] **THE TRAVELERS INSURANCE COMPANIES** para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] **06-06-15** . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy].
THE TRAVELERS INSURANCE COMPANIES

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

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

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EMPLEADOR CON COBERTURA

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WORKERS' COMPENSATION NOTICE THAT

Employer: BC TECHNICAL, INC.

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act

by insuring with **Insurance Carrier:** THE TRAVELERS INSURANCE COMPANIES

Policy Number: (HJUB-6E20721-A-15)

Address for the above insurance carrier is P.O. BOX 173762 DENVER, CO 80217-3762

Telephone number is 1-800-238-6225

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury – no matter how slight – to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)
2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.
3. 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.
4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.
2. Ask your doctor to send a medical report to that insurance company.
3. Ask your employer to send a report of the accident to that insurance company.
4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, 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, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

WORKERS' COMPENSATION NOTICE THAT

Employer: BC TECHNICAL, INC.

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act

by insuring with **Insurance Carrier:** THE TRAVELERS INSURANCE COMPANIES

Policy Number: (HJUB-6E20721-A-15)

Address for the above insurance carrier is P.O. BOX 173762 DENVER, CO 80217-3762

Telephone number is 1-800-238-6225

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury – no matter how slight – to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)
2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.
3. 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.
4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.
2. Ask your doctor to send a medical report to that insurance company.
3. Ask your employer to send a report of the accident to that insurance company.
4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

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NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

COMPENSACIÓN AL TRABAJADOR
NOTE QUE

BC TECHNICAL, INC.

La empresa: _____

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Titulo §34A-2-101, en el libro de Código de Utah anatado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensactión y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: **THE TRAVELERS INSURANCE COMPANIES**

No. de Póliza: **(HJUB-6E20721-A-15)**

Dirección de la compañía de seguros: **P.O. BOX 173762 DENVER, CO 80217-3762**

Numero de teléfono: **1-800-238-6225**

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – su supervisor immediatamente. (Pierde sus derechos no reporta su accidente entre 180 dias después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compania de seguro dentro De los primeros siete (7) dias del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatemente para obtener tratamiento, Si no, vaya al doctor de su preferencia.
4. Digale al doctor CÓMO, CUÁNDO Y DÓNDE ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) dias de su visita a (1) la compañia de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah require lo siguiente que aparezca en esta forma, cualquier persona que intensionalmente presente información false o fraudulenta, que abara o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de factusas de gastos médicos u otros servicios profesionales es calpable de crimen y puede ser sujeto a multas y encarceuado en la prisión del Estada."

ESTADO DE UTAH

COMISION LABORAL

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensacion al Trabajador o si tiene preguntas, llame a la Comisión Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Articulo §34A-2-204, en el libro de Código de Utah anatado en 1997.

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No. de Póliza: **(HJUB-6E20721-A-15)**

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Form VWCI

ISSUED TO: **BC TECHNICAL, INC.**

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, VA 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.

Form VWCI

ISSUED TO: **BC TECHNICAL, INC.**

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ISSUED TO: **BC TECHNICAL, INC.**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation 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
1000 DMV Drive
Richmond, VA 23220
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.

ISSUED TO: **BC TECHNICAL, INC.**

NOTICIA SOBRE COMPENSACIÓN LABORAL

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NAME INSURED: BC TECHNICAL, INC.

POLICY NUMBER: (HJUB-6E20721-A-15)

EFFECTIVE DATE: 06-06-15

GUNTHER OPERATOR:

MANUALLY INSERT 4 COPIES OF THE COLORADO OVERSIZED POSTING NOTICE CP-5992 – YELLOW CARD STOCK

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: BC TECHNICAL, INC.

POLICY NUMBER: (HJUB-6E20721-A-15)

EFFECTIVE DATE: 06-06-15

GUNTHER OPERATOR:

MANUALLY INSERT 6 COPIES OF THE FLORIDA OVERSIZED POSTING NOTICES

W09P1 — (ENGLISH)

AND

W09P2 — (SPANISH)

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER—Name: BC TECHNICAL, INC.
Address: 7172 S AIRPORT RD
WEST JORDAN UT 84084

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES
Address: (VARIES BY LOCATION)

AGENT—Name: LOCKTON COMPANIES LLC

POLICY NUMBER: (HJUB-6E20721-A-15)

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

POLICY NUMBER: (HJUB-6E20721-A-15)

EFFECTIVE DATE: 06-06-15

BC TECHNICAL, INC.

GUNTHER OPERATOR:

MANUALLY INSERT 2 COPIES OF W19P1

MARYLAND OVERSIZED POSTING NOTICES

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER—Name: BC TECHNICAL, INC.
7172 S AIRPORT RD
Address: WEST JORDAN UT 84084

Telephone No. (801) 208-6807 FEIN: 870550892

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

MANUAL INSERT REQUIRED

W19X1O08

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: BC TECHNICAL, INC.

POLICY NUMBER: (HJUB-6E20721-A-15)

EFFECTIVE DATE: 060615

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W27P1

NEVADA OVERSIZED POSTING NOTICES

ATTACH NEVADA STICKERS

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

POLICY NUMBER: (HJUB-6E20721-A-15)

EFFECTIVE DATE: 06-06-15

BC TECHNICAL, INC.

GUNTHER OPERATOR:

MANUALLY INSERT 3 COPIES OF W39P1

SOUTH CAROLINA OVERSIZED POSTING NOTICES

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER—Name: BC TECHNICAL, INC.

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES
Address: 200 CENTER POINT CIRCLE SUITE 340,
COLUMBIA, SC 29210

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

W39X1M06

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

STICKER LABELS AND/OR POSTING NOTICES FOR MANUAL INSERT

FOR POLICY PRINTED IN JOB #: G664063

Named Insured: BC TECHNICAL, INC.

Policy Number: (HJUB-6E20721-A-15)

Effective Date: 06-06-15

MANUAL INSERT INFORMATION

MANUAL INSERT INFORMATION

EMPLOYER – Name: BC TECHNICAL, INC.
7172 S AIRPORT RD
Address: WEST JORDAN UT 84084

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 06-06-15
POLICY NUMBER: (HJUB -6E20721-A-15) Exp. Date: 06-06-16

EMPLOYER – Name: BC TECHNICAL, INC.
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ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 06-06-15
POLICY NUMBER: (HJUB -6E20721-A-15) Exp. Date: 06-06-16

EMPLOYER – Name: BC TECHNICAL, INC.
7172 S AIRPORT RD
Address: WEST JORDAN UT 84084

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 06-06-15
POLICY NUMBER: (HJUB -6E20721-A-15) Exp. Date: 06-06-16

EMPLOYER – Name: BC TECHNICAL, INC.
7172 S AIRPORT RD
Address: WEST JORDAN UT 84084

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 06-06-15
POLICY NUMBER: (HJUB -6E20721-A-15) Exp. Date: 06-06-16

FL

EMPLOYER – Name: BC TECHNICAL, INC.
Address: 7172 S AIRPORT RD
WEST JORDAN UT 84084

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC
POLICY NUMBER: (HJUB -6E20721-A-15)
Eff. Date: 06-06-15
Exp. Date: 06-06-16

EMPLOYER – Name: BC TECHNICAL, INC.
Address: 7172 S AIRPORT RD
WEST JORDAN UT 84084

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC
POLICY NUMBER: (HJUB -6E20721-A-15)
Eff. Date: 06-06-15
Exp. Date: 06-06-16

EMPLOYER – Name:
Address:

CARRIER – Name:
Address:

AGENT – Name:
POLICY NUMBER:
Eff. Date:
Exp. Date:

EMPLOYER – Name:
Address:

CARRIER – Name:
Address:

AGENT – Name:
POLICY NUMBER:
Eff. Date:
Exp. Date:

EMPLOYER – Name: BC TECHNICAL, INC.
Address: 7172 S AIRPORT RD
WEST JORDAN UT 84084

Telephone No. (801) 208-6807

FEIN: 870550892

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name: BC TECHNICAL, INC.
Address: 7172 S AIRPORT RD
WEST JORDAN UT 84084

Telephone No. (801) 208-6807

FEIN: 870550892

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

Address:

Telephone No.

FEIN:

CARRIER – Name:

Telephone No.

POLICY NUMBER:

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON: CLAIM MANAGER
Address: P.O. BOX 14246
ORANGE, CA 92863-1246

Telephone No. 1-800-238-6225

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

ISSUED TO: BC TECHNICAL, INC.

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address:

Telephone No.

EMPLOYER – Name: BC TECHNICAL, INC.

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: 200 CENTER POINT CIRCLE SUITE 340
COLUMBIA, SC 29210

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

EMPLOYER – Name: BC TECHNICAL, INC.

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: 200 CENTER POINT CIRCLE SUITE 340
COLUMBIA, SC 29210

Telephone No. (800) 238-6225

POLICY NUMBER: 6E20721A

EMPLOYER – Name:

CARRIER – Name:
Address:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

CARRIER – Name:
Address:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

CARRIER – Name:
Address:

Telephone No.

POLICY NUMBER:

EMPLOYER – Name:

CARRIER – Name:
Address:

Telephone No.

POLICY NUMBER:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY OVERPRINT PAGE

POLICY NUMBER: **(HJUB-6E20721-A-15)**

INSURED'S NAME: **BC TECHNICAL, INC.**

POLICY EFFECTIVE: **06-06-15** POLICY EXPIRY: **06-06-16**

NEW/RENEWAL: **R**	SOLICITOR:	SAI: **1943N8096**
RESPONSIBILITY: **H**	MSI:	SIC CODE: **3841**
PAYMODE/ DIRECT BILL CODE: **M**	AUDIT FREQUENCY: **A**	REINSURANCE:
WATCH FILE: **0**	SURVEY CODE: **0**	NEG COMM: **.0500**
PROGRAM CODE: **SDM**	NBR OF POL IN SAI:	AGENCY BILL: **Y**
AMS BINDER #:	PARENT FEIN: **870550892**	NAICS: **339112**
PKG POL NBR:		

STATE PREDOMINANT CLASS & SYMBOL (* indicates if selected as Policy predominant)

ST	ST POLICY SYMBOL		ST PREDOM CLASS	ST	ST POLICY SYMBOL	ST PREDOM CLASS
AL	**HFUB**		**5191**	**AZ**	**HCUB**	**5191**
CA	**HJUB**	*	**5128**	**CO**	**HSUB**	**5191**
CT	**HCUB**		**5191**	**FL**	**HJUB**	**5191**
GA	**HKUB**		**5191**	**IL**	**HFUB**	**3685**
IN	**HCUB**		**3685**	**KS**	**HFUB**	**5191**
KY	**HJUB**		**5191**	**LA**	**HFUB**	**5191**
MA	**HHUB**		**5191**	**MD**	**HCUB**	**5191**
MI	**HCUB**		**5191**	**MN**	**HCUB**	**5191**
MO	**HSUB**		**5191**	**NC**	**HFUB**	**5191**
NE	**HKUB**		**5191**	**NJ**	**HJUB**	**5191**
NV	**HJUB**		**5191**	**NY**	**HJUB**	**5191**
OH	**HJUB**		**5191**	**OK**	**HJUB**	**5191**
OR	**HJUB**		**5191**	**PA**	**HSUB**	**0952**
SC	**HNUB**		**5191**	**TN**	**HFUB**	**5191**
TX	**HCUB**		**5191**	**UT**	**HNUB**	**3685**
VA	**HJUB**		**5191**	**WA**	**HJUB**	**5191**
WI	**HJUB**		**5191**			

OFFICE: **ST LOUIS 184**
PRODUCER: **LOCKTON COMPANIES LLC 54274** RATER: **DS**
ISSUE DATE: **06-25-15** CHANGE EFFECTIVE DATE: **06-06-15**

WUNT6H96

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

COMMISSION/INSTALLMENT SUMMARY

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
06-15	06/06/15	167.00	#(A2)	.0000
06-15	06/06/15	10.00	#(62)	.0000
06-15	06/06/15	4.00	#(B6)	.0000
06-15	06/06/15	34.00	#(32)	.0000
06-15	06/06/15	13.00	#(28)	.0000
06-15	06/06/15	17.00	#(D3)	.0000
06-15	06/06/15	18.00	#(37)	.0000
06-15	06/06/15	4.00	#(D1)	.0000
06-15	06/06/15	16.00	#(B0)	.0000
06-15	06/06/15	13.00	#(A9)	.0000
06-15	06/06/15	7.00	#(35)	.0000
06-15	06/06/15	47.00	#(63)	.0000
06-15	06/06/15	31.00	#(59)	.0000
06-15	06/06/15	9.00	#(43)	.0000
06-15	06/06/15	10726.00		.0500
TOTALS		$ 11116.00		
07-15	07/06/15	167.00	#(A2)	.0000
07-15	07/06/15	4.00	#(62)	.0000
07-15	07/06/15	1.00	#(B6)	.0000
07-15	07/06/15	7.00	#(28)	.0000
07-15	07/06/15	31.00	#(32)	.0000
07-15	07/06/15	10.00	#(D3)	.0000
07-15	07/06/15	14.00	#(37)	.0000
07-15	07/06/15	2.00	#(D1)	.0000
07-15	07/06/15	5.00	#(A9)	.0000
07-15	07/06/15	9.00	#(B0)	.0000
07-15	07/06/15	4.00	#(35)	.0000
07-15	07/06/15	4.00	#(43)	.0000
07-15	07/06/15	24.00	#(59)	.0000
07-15	07/06/15	42.00	#(63)	.0000
07-15	07/06/15	10490.00		.0500
TOTALS		$ 10814.00		
08-15	08/06/15	167.00	#(A2)	.0000
08-15	08/06/15	4.00	#(62)	.0000
08-15	08/06/15	1.00	#(B6)	.0000
08-15	08/06/15	31.00	#(32)	.0000
08-15	08/06/15	7.00	#(28)	.0000

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ACCT MO	EFF DATE		GROSS AMT		COMM RATE
08-15	08/06/15		10.00	#(D3)	.0000
08-15	08/06/15		14.00	#(37)	.0000
08-15	08/06/15		2.00	#(D1)	.0000
08-15	08/06/15		9.00	#(B0)	.0000
08-15	08/06/15		5.00	#(A9)	.0000
08-15	08/06/15		4.00	#(35)	.0000
08-15	08/06/15		42.00	#(63)	.0000
08-15	08/06/15		24.00	#(59)	.0000
08-15	08/06/15		4.00	#(43)	.0000
08-15	08/06/15		10490.00		.0500
TOTALS		$	10814.00		
09-15	09/06/15		167.00	#(A2)	.0000
09-15	09/06/15		4.00	#(62)	.0000
09-15	09/06/15		1.00	#(B6)	.0000
09-15	09/06/15		7.00	#(28)	.0000
09-15	09/06/15		31.00	#(32)	.0000
09-15	09/06/15		10.00	#(D3)	.0000
09-15	09/06/15		14.00	#(37)	.0000
09-15	09/06/15		5.00	#(A9)	.0000
09-15	09/06/15		9.00	#(B0)	.0000
09-15	09/06/15		2.00	#(D1)	.0000
09-15	09/06/15		4.00	#(35)	.0000
09-15	09/06/15		4.00	#(43)	.0000
09-15	09/06/15		24.00	#(59)	.0000
09-15	09/06/15		42.00	#(63)	.0000
09-15	09/06/15		10490.00		.0500
TOTALS		$	10814.00		
10-15	10/06/15		4.00	#(62)	.0000
10-15	10/06/15		1.00	#(B6)	.0000
10-15	10/06/15		167.00	#(A2)	.0000
10-15	10/06/15		31.00	#(32)	.0000
10-15	10/06/15		7.00	#(28)	.0000
10-15	10/06/15		10.00	#(D3)	.0000
10-15	10/06/15		14.00	#(37)	.0000
10-15	10/06/15		2.00	#(D1)	.0000
10-15	10/06/15		9.00	#(B0)	.0000
10-15	10/06/15		5.00	#(A9)	.0000
10-15	10/06/15		4.00	#(35)	.0000
10-15	10/06/15		42.00	#(63)	.0000
10-15	10/06/15		24.00	#(59)	.0000
10-15	10/06/15		4.00	#(43)	.0000

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
10-15	10/06/15	10490.00		.0500
TOTALS		$ 10814.00		
11-15	11/06/15	4.00	#(62)	.0000
11-15	11/06/15	1.00	#(B6)	.0000
11-15	11/06/15	167.00	#(A2)	.0000
11-15	11/06/15	7.00	#(28)	.0000
11-15	11/06/15	31.00	#(32)	.0000
11-15	11/06/15	14.00	#(37)	.0000
11-15	11/06/15	10.00	#(D3)	.0000
11-15	11/06/15	5.00	#(A9)	.0000
11-15	11/06/15	9.00	#(B0)	.0000
11-15	11/06/15	2.00	#(D1)	.0000
11-15	11/06/15	4.00	#(35)	.0000
11-15	11/06/15	4.00	#(43)	.0000
11-15	11/06/15	24.00	#(59)	.0000
11-15	11/06/15	42.00	#(63)	.0000
11-15	11/06/15	10490.00		.0500
TOTALS		$ 10814.00		
12-15	12/06/15	4.00	#(62)	.0000
12-15	12/06/15	1.00	#(B6)	.0000
12-15	12/06/15	167.00	#(A2)	.0000
12-15	12/06/15	7.00	#(28)	.0000
12-15	12/06/15	14.00	#(37)	.0000
12-15	12/06/15	10.00	#(D3)	.0000
12-15	12/06/15	2.00	#(D1)	.0000
12-15	12/06/15	9.00	#(B0)	.0000
12-15	12/06/15	5.00	#(A9)	.0000
12-15	12/06/15	4.00	#(35)	.0000
12-15	12/06/15	42.00	#(63)	.0000
12-15	12/06/15	24.00	#(59)	.0000
12-15	12/06/15	4.00	#(43)	.0000
12-15	12/06/15	31.00	#(32)	.0000
12-15	12/06/15	10490.00		.0500
TOTALS		$ 10814.00		
01-16	01/06/16	4.00	#(62)	.0000
01-16	01/06/16	1.00	#(B6)	.0000
01-16	01/06/16	167.00	#(A2)	.0000
01-16	01/06/16	7.00	#(28)	.0000
01-16	01/06/16	14.00	#(37)	.0000
01-16	01/06/16	10.00	#(D3)	.0000

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ACCT MO	EFF DATE		GROSS AMT		COMM RATE
01-16	01/06/16		5.00	#(A9)	.0000
01-16	01/06/16		9.00	#(B0)	.0000
01-16	01/06/16		2.00	#(D1)	.0000
01-16	01/06/16		4.00	#(35)	.0000
01-16	01/06/16		31.00	#(32)	.0000
01-16	01/06/16		4.00	#(43)	.0000
01-16	01/06/16		24.00	#(59)	.0000
01-16	01/06/16		42.00	#(63)	.0000
01-16	01/06/16		10490.00		.0500
TOTALS		$	10814.00		
02-16	02/06/16		4.00	#(62)	.0000
02-16	02/06/16		1.00	#(B6)	.0000
02-16	02/06/16		167.00	#(A2)	.0000
02-16	02/06/16		7.00	#(28)	.0000
02-16	02/06/16		10.00	#(D3)	.0000
02-16	02/06/16		14.00	#(37)	.0000
02-16	02/06/16		2.00	#(D1)	.0000
02-16	02/06/16		9.00	#(B0)	.0000
02-16	02/06/16		5.00	#(A9)	.0000
02-16	02/06/16		42.00	#(63)	.0000
02-16	02/06/16		4.00	#(35)	.0000
02-16	02/06/16		24.00	#(59)	.0000
02-16	02/06/16		4.00	#(43)	.0000
02-16	02/06/16		31.00	#(32)	.0000
02-16	02/06/16		10490.00		.0500
TOTALS		$	10814.00		
03-16	03/06/16		4.00	#(62)	.0000
03-16	03/06/16		1.00	#(B6)	.0000
03-16	03/06/16		167.00	#(A2)	.0000
03-16	03/06/16		7.00	#(28)	.0000
03-16	03/06/16		14.00	#(37)	.0000
03-16	03/06/16		10.00	#(D3)	.0000
03-16	03/06/16		5.00	#(A9)	.0000
03-16	03/06/16		9.00	#(B0)	.0000
03-16	03/06/16		2.00	#(D1)	.0000
03-16	03/06/16		42.00	#(63)	.0000
03-16	03/06/16		4.00	#(35)	.0000
03-16	03/06/16		31.00	#(32)	.0000
03-16	03/06/16		4.00	#(43)	.0000
03-16	03/06/16		24.00	#(59)	.0000

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE**

POLICY NUMBER: **(HJUB-6E20721-A-15)**

ACCT MO	EFF DATE	GROSS AMT	COMM RATE
03-16	03/06/16	10490.00	.0500

TOTALS	$	10814.00

#(B6) PENNSLYVANIA EMPLOYER ASSESSMENT SURCHARGE
#(62) MISSOURI WORKERS COMPENSATION SECOND INJURY FUND SURCHARGE
#(D3) ILLINOIS INDUSTRIAL COMMISSION FUND
#(A9) CT ASSESSMENT FUND
#(B0) CT SECOND INJURY FUND SURCHARGE - VOLUNTARY
#(D1) INDIANA SECOND INJURY FUND
#(37) MINNESOTA SPECIAL COMPENSATION FUND
#(35) MASS SURCHARGE-WORKERS COMPENSATION
#(A2) NEW YORK STATE ASSESSMENT
#(28) OREGON WORKERS COMPENSATION DEPARTMENT ASSESSMENTS
#(32) CIGA SURCHARGE-WORKERS COMPENSATION
#(43) KENTUCKY SPECIAL FUND ASSESSMENT
#(59) CA WC FRAUD ASSESSMENT
#(63) NEW JERSEY SECOND INJURY FUND SURCHARGE

STATE PREDOMINANT COUNTY/TOWN INFORMATION

ST ABBR.	PREDOMINANT CNTY/TOWN CODE
AL	9999
LA	0252