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:**

**SPECIALTY MEDICAL SYSTEMS, INC**
**1911 BROADWAY**
**KANSAS CITY MO 64108**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**TYPE V INFORMATION PAGE WC 00 00 01 ( A)**

**POLICY NUMBER: (HHUB-6E81767-4-14)**

**NEW-14**

**INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA**

**NCCI CO CODE: 13439**

**1.**

**INSURED:**

**SPECIALTY MEDICAL SYSTEMS, INC**
**1911 BROADWAY**
**KANSAS CITY MO 64108**

**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 **06-29-14** to **06-29-15** 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:

**FL IA IL KS KY MO NE**

**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:

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

**D.** This policy includes these endorsements and schedules:

**SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE**

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

**DATE OF ISSUE: 07-10-14 ST**
**OFFICE: ST LOUIS 184 DIRECT BILL**
**PRODUCER: LOCKTON COMPANIES LLC BXY10**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**TYPE V INFORMATION PAGE WC 00 00 01 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**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**

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| | | STANDARD |
|---|---|---|
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | $ | 34932 |
| PREMIUM DISCOUNT | | 1408 |
| 0900-12 EXPENSE CONSTANT | | 280 |
| TERRORISM | | 407 |
| CAT (OTHER THAN CERT ACTS OF TERRORISM) | | 81 |
| TOTAL ESTIMATED PREMIUM | | 34292 |
| TAXES AND SURCHARGES | | 1642 |
| DEPOSIT AMOUNT DUE | | 35934 |

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

DATE OF ISSUE: **07-10-14 ST**
OFFICE: **ST LOUIS 184**
PRODUCER: **LOCKTON COMPANIES LLC BXY10**

**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: **(HHUB-6E81767-4-14)**

**INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

**13579-FL**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, FL 33643<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **3044** | **.03** | **91** |
| **INSTRUMENT MFG. NOC** | **3685** | **232761** | **1.23** | **2863** |
| **SALESPERSONS OR COLLECTORS - OUTSIDE** | **8742** | **IF ANY** | **.52** | |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| CLERICAL OFFICE EMPLOYEES NOC | 8810 | 69549 | .26 | 181 |

**FL MANUAL PREMIUM $ 3044**

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| | |
|---|---|
| 1.40% EMPL. LIAB. INCREASED LIMITS(9812) | $ 43 |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | 3178 |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | 2352 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | 2352 |
| 6.50% PREMIUM DISCOUNT (0063) | 153 |
| TERRORISM (9740) | 60 |
| TOTAL ESTIMATED PREMIUM | 2259 |
| DEPOSIT AMOUNT DUE | 2259 |

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: **(HHUB-6E81767-4-14)**

**INSURER: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT**

**12637-IA**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, IA 50301<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **4396** | **.02** | **88** |
| **INSTRUMENT MFG. NOC** | **3685** | **132696** | **2.70** | **3583** |
| **DRIVERS, CHAUFFEURS, MESSENG-<br>ERS, AND THEIR HELPERS NOC-<br>COMMERCIAL** | **7380** | **IF ANY** | **6.57** | |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| SALESPERSONS OR COLLECTORS - OUTSIDE | 8742 | 133294 | .61 | 813 |

**IA MANUAL PREMIUM $ 4396**

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| | |
|---|---|
| 1.10% EMPL. LIAB. INCREASED LIMITS(9812) | $ 48 |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | 4532 |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | 3354 |
| DEVIATION PROGRAM CREDIT(9034) - 15.00% | 503 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | 2851 |
| 6.50% PREMIUM DISCOUNT (0063) | 185 |
| TERRORISM (9740) | 53 |
| CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741 | 27 |
| TOTAL ESTIMATED PREMIUM | 2746 |
| DEPOSIT AMOUNT DUE | 2746 |

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: **(HHUB-6E81767-4-14)**

**INSURER: FARMINGTON CASUALTY COMPANY**

**22640-IL**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, IL 62701<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **IF ANY** | **.02** | |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| SALESPERSONS OR COLLECTORS - OUTSIDE | 8742 | IF ANY | .28 | |

**IL MANUAL PREMIUM $ 0**

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| | |
|---|---|
| 1.40% EMPL. LIAB. INCREASED LIMITS | $ NONE |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | NONE |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | NONE |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | NONE |
| 3.60% PREMIUM DISCOUNT | NONE |
| EXPENSE CONSTANT (0900) | 280 |
| TERRORISM (9740) | NONE |
| CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741 | NONE |
| 1.01% IL IND COMM OP FUND SURCHARGE | 3 |
| TOTAL ESTIMATED PREMIUM | 283 |
| DEPOSIT AMOUNT DUE | 283 |

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: **(HHUB-6E81767-4-14)**

**INSURER: THE TRAVELERS INDEMNITY COMPANY**

**11347-KS**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, KS 66601<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **2161** | **.02** | **43** |
| **INSTRUMENT MFG. NOC** | **3685** | **100607** | **1.08** | **1087** |
| **DRIVERS, CHAUFFEURS, MESSENG-<br>ERS, AND THEIR HELPERS NOC-<br>COMMERCIAL** | **7380** | **9830** | **4.23** | **416** |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| SALESPERSONS OR COLLECTORS - OUTSIDE | 8742 | 173207 | .38 | 658 |

**KS MANUAL PREMIUM $ 2161**

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| | |
|---|---|
| 1.10% EMPL. LIAB. INCREASED LIMITS(9812) | $ 24 |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | 2228 |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | 1649 |
| 10.00% SCHEDULE CREDIT (9887) | 165 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | 1484 |
| 3.60% PREMIUM DISCOUNT(0064) | 53 |
| TERRORISM (9740) | 28 |
| CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741 | 28 |
| TOTAL ESTIMATED PREMIUM | 1487 |
| DEPOSIT AMOUNT DUE | 1487 |

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: **(HHUB-6E81767-4-14)**

**INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA**

**13439-KY**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **1 ST. JOSEPH DR.<br>LEXINGTON, KY 40504<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **INSTRUMENT MFG. NOC** | **3685** | **207119** | **1.28** | **2651** |

**KY MANUAL PREMIUM $ 2651**

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| | |
|---|---|
| **1.10% EMPL. LIAB. INCREASED LIMITS(9812) $** | **29** |
| **TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION** | **2680** |
| **EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM** | **1983** |
| **TOTAL ESTIMATED ANNUAL STANDARD PREMIUM** | **1983** |
| **3.60% PREMIUM DISCOUNT(0064)** | **71** |
| **TERRORISM (9740)** | **21** |
| **CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741** | **21** |
| **6.28% KY SPECIAL FUND ASSESSMENT** | **123** |
| **TOTAL ESTIMATED PREMIUM** | **2077** |
| **DEPOSIT AMOUNT DUE** | **2077** |

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: **(HHUB-6E81767-4-14)**

**INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA**

**13439-MO**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **1911 BROADWAY<br>KANSAS CITY, MO 64108<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **34728** | **.02** | **695** |
| **INSTRUMENT MFG. NOC** | **3685** | **1499977** | **1.39** | **20850** |
| **DRIVERS, CHAUFFEURS, MESSENGERS, AND THEIR HELPERS NOC-COMMERCIAL** | **7380** | **223373** | **5.01** | **11191** |
| **SALESPERSONS OR COLLECTORS - OUTSIDE** | **8742** | **449828** | **.49** | **2204** |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| CLERICAL OFFICE EMPLOYEES NOC | 8810 | 229924 | .21 | 483 |

**MO MANUAL PREMIUM $ 34728**

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| | |
|---|---|
| 1.10% EMPL. LIAB. INCREASED LIMITS(9812) | $ 382 |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | 35805 |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | 26496 |
| 2.00% SCHEDULE CREDIT(9887) | 530 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | 25966 |
| 3.60% PREMIUM DISCOUNT(0064) | 935 |
| TERRORISM (9740) | 240 |
| 6.00% MO SECOND INJURY FUND SURCHARGE | 1516 |
| 1.00% MO ADMINISTRATIVE SURCHARGE | NONE |
| TOTAL ESTIMATED PREMIUM | 26787 |
| DEPOSIT AMOUNT DUE | 26787 |

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: **(HHUB-6E81767-4-14)**

**INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

**13579-ND**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, ND 58501<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **SALESPERSONS-OUTSIDE<br>INCLUDED IN ** OTHER CHARGES** | **8742** | **IF ANY** | **.0220** | |

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| | |
|---|---|
| **EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM $** | **NONE** |
| **TOTAL ESTIMATED ANNUAL STANDARD PREMIUM** | **NONE** |
| **TERRORISM (9740)** | **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: **(HHUB-6E81767-4-14)**

**INSURER: THE TRAVELERS INDEMNITY COMPANY**

**11347-NE**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

**RATE BUREAU ID: 911118262**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, NE 68501<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **BLANKET WAIVER<br>SEE ENDT. WC 00 03 13 (00)-001<br>WAIVER CALCULATION IS BASED ON<br>CLASS CODE(S) PREMIUM X RATE.** | **0930** | **388** | **.02** | **8** |
| **INSTRUMENT MFG. NOC** | **3685** | **25446** | **1.23** | **313** |
| **DRIVERS, CHAUFFEURS, MESSENG-<br>ERS, AND THEIR HELPERS NOC-<br>COMMERCIAL** | **7380** | **IF ANY** | **4.11** | |

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: **(HHUB-6E81767-4-14)**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| LOCATION 001 01 (CONT'D) | | | | |
| SALESPERSONS OR COLLECTORS - OUTSIDE | 8742 | 19827 | .38 | 75 |

**NE MANUAL PREMIUM $ 388**

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| | |
|---|---|
| 1.10% EMPL. LIAB. INCREASED LIMITS(9812) | $ 4 |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION | 400 |
| EXPERIENCE MODIFICATION: .74 MODIFIED PREMIUM | 296 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM | 296 |
| 3.60% PREMIUM DISCOUNT(0064) | 11 |
| TERRORISM (9740) | 5 |
| CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741 | 5 |
| TOTAL ESTIMATED PREMIUM | 295 |
| DEPOSIT AMOUNT DUE | 295 |

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: **(HHUB-6E81767-4-14)**

**INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

**13579-OH**

**INSURED'S NAME: SPECIALTY MEDICAL SYSTEMS, INC**

| CLASSIFICATION | CODE | PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION | RATES PER $100 OF REMUNERATION | ESTIMATED ANNUAL PREMIUM |
|---|---|---|---|---|
| **LOCATION 001 01** | | | | |
| **FEIN 481108590 ENTITY CD 001** | | | | |
| **SPECIALTY MEDICAL SYSTEMS, INC** | | | | |
| **NO BUSINESS LOCATION<br>NONE, OH 43085<br>SIC CODE: 3841 NAICS: 339112** | | | | |
| **SALESPERSONS-OUTSIDE<br>INCLUDED IN ** OTHER CHARGES** | **8742** | **IF ANY** | **.0220** | |

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| | |
|---|---|
| **EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM $** | **NONE** |
| **TOTAL ESTIMATED ANNUAL STANDARD PREMIUM** | **NONE** |
| **TERRORISM (9740)** | **NONE** |
| **TOTAL ESTIMATED PREMIUM** | **NONE** |
| **DEPOSIT AMOUNT DUE** | **NONE** |

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 00 01 (A )**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

## LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

| | |
|---|---|
| WC 00 00 01 A - 001 | INFORMATION PAGE |
| WC 00 00 01 A - 001 | INFORMATION PAGE 2 |
| WC 00 00 01 A - 001 | EXTENSION OF INFORMATION PAGE - SCHEDULE |
| WC 00 00 01 A - 001 | ENDORSEMENT LISTING |
| WC 24 04 06 C - 001 | MO EMPLOYER PAID MEDICAL ENDT |
| WC 00 01 14 00 - 001 | PENDING LAW CHANGE TO TERRORISM RISK INS |
| WC 00 03 03 C - 001 | EMPLOYERS LIAB COVERAGE ENDT |
| WC 00 03 13 00 - 001 | WAIVER OF OUR RIGHT TO RECOVER |
| WC 00 04 14 00 - 001 | NOTIFICATION OF CHANGE IN OWNERSHIP ENDT |
| WC 00 04 22 A - 001 | TERRORISM-REAUTHORIZATION ACT DISCLOSURE |
| WC 09 04 03 A - 001 | FL TRIPA ENDT |
| WC 99 03 D3 A - 001 | OH EMPLOYERS LIAB COVERAGE ENDORSEMENT |
| WC 99 06 99 00 - 001 | ND AMENDATORY ENDORSEMENT |
| W09N1I13 | FL PENDING LAW CHANGE TO TERR RISK INS |
| WC 00 04 21 C - 001 | CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT |
| WC 99 04 08 00 - 001 | PREMIUM DISCOUNT ENDORSEMENT |
| WC 99 01 19 A - 001 | TERRORSM RISK INSURANCE PROGRAM ENDT |
| WC 99 01 19 00 - 001 | TERRORISM RISK INSURANCE PRG ACT ENDT |
| WC 00 04 19 00 - 001 | PREMIUM DUE DATE 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 12 06 01 D - 001 | ILLINOIS AMENDATORY ENDORSEMENT |
| 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 24 03 02 00 - 001 | MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT |
| WC 24 04 01 00 - 001 | MISSOURI CONTRACTING CLASS PREM ADJ 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 99 06 46 00 - 001 | ILLINOIS AMENDATORY ENDORSEMENT |

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 00 01 14 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# NOTIFICATION ENDORSEMENT OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

This endorsement is being sent to you with respect to your workers compensation and employers liability insurance policy. This endorsement does not replace the separate Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 A) that is attached to your current policy and which remains in effect as applicable.

The Terrorism Risk Insurance Act of 2002 (TRIA) as previously amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007 (TRIPRA), provides for a program under which the federal government will share in the payment of insured losses caused by certain acts of terrorism. In the absence of affirmative US Congressional action to extend, update, or otherwise reauthorize TRIPRA, in whole or in part, TRIPRA is scheduled to expire December 31, 2014.

Since the timetable for any further Congressional action respecting TRIPRA is unknown at this time, and exposure to acts of terrorism remains, we are providing our policyholders with relevant information concerning their workers compensation policies in effect on or after January 1, 2014 in the event of TRIPRA's expiration.

Your policy provides coverage for workers compensation losses caused by acts of terrorism or war, including workers compensation benefit obligations dictated by state law, except in Pennsylvania where injuries or deaths resulting from certain war-related activities are excluded from workers compensation coverage. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy.

**The premium charge for the coverage your policy provides for terrorism or war losses is shown in Item 4 of the Information Page or the Schedule in the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 A) that is attached to your policy, and this amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2014 in the event of TRIPRA's expiration, subject to regulatory review in accordance with applicable state law.**

You need not do anything further at this time.

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: **07-10-14** ST ASSIGN: 

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 03 03 ( C)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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**

**ND**

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: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 03 13 (00)-01**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit any one not named in the Schedule.

**SCHEDULE**

**DESIGNATED PERSON:**

**DESIGNATED ORGANIZATION:**

**ANY PERSON OR ORGANIZATION FOR WHICH THE INSURED HAS AGREED BY WRITTEN CONTRACT EXECUTED PRIOR TO LOSS TO FURNISH THIS WAIVER.**

DATE OF ISSUE: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 04 14 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 04 22 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

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

**Definitions**

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

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.

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

**a.** The act is an act of terrorism.

**b.** The act is violent or dangerous to human life, property or infrastructure.

**c.** The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

**d.** The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

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

"Insurer Deductible" means, for the period beginning on January 1, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.

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

**Limitation of Liability**

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 04 22 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**Policyholder Disclosure Notice**

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed $100,000,000 in a Program Year, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

**Schedule**

| State | Rate | Premium |
|---|---|---|

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 09 04 03 (A )**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 2007.

**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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States as meeting all of the following requirements:
   a. The act is an act of terrorism.
   b. The act is violent or dangerous to human life, property or infrastructure.
   c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
   d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
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, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.
5. "Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

**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 Program 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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 09 04 03 (A )**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**Policyholder Disclosure Notice**

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceeds $100,000,000 in a Program Year, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceeds $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

**Schedule**

Rate per $100 of 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 _____

DATE OF ISSUE: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 03 D3 ( A) – 001**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 POLICY**

**ENDORSEMENT WC 99 06 99 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# NORTH DAKOTA AMENDATORY ENDORSEMENT (EMPLOYERS LIABILITY COVERAGE)

This endorsement applies only to work in North Dakota.

We agree that PART FIVE - PREMIUM, Item G. Audit is amended as follows:

**1.** Except as provided in 2. below, we may examine and audit your books and records as they relate to this policy at any time during the policy period and up to three years afterward.

**2.** Any audit conducted to determine the premium due or to be refunded must be completed within 180 days after:

**a.** The expiration date of the policy; or

**b.** The anniversary date, if this is a continuous policy or a policy written for a term longer than one year;

unless you agree in writing to extend the audit period.

It is also agreed that PART SIX - CONDITIONS, D. Cancellation item number 2 is amended as follows:

We may cancel this policy by mailing or delivering to you at the address shown on the Information Page written notice stating when A) not less than ten days thereafter in the case of Non-Payment of premium, or B) not less than 30 days thereafter, in all other cases, such cancellation shall be effective.

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 04 21 ( C)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (other than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 A), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (other than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of $50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
  - **a.** It is an act that is violent or dangerous to human life, property, or infrastructure;
  - **b.** The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
  - **c.** It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (other than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

**Schedule**

| State | Rate | Premium |
|---|---|---|

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

**(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)**

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 04 08 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 01 19 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# TERRORISM RISK INSURANCE PROGRAM ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended.

**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 resulting thereto:

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

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

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

"Insurer Deductible" means, for the period beginning on January 1, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.

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

**Limitation of Liability**

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 01 19 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**Policyholder Disclosure Notice**

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceeds $100,000,000 in a Program Year, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amounts 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 _____

DATE OF ISSUE: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 01 19 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007.

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

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

**a.** The act is an act of terrorism.

**b.** The act is violent or dangerous to human life, property or infrastructure.

**c.** The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

**d.** The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

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

"Insurer Deductible" means, for the period beginning on January 1, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.

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

**Limitation of Liability**

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 01 19 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**Policyholder Disclosure Notice**

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceeds $100,000,000 in a Program Year, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amounts shown in Item 4 of the Information Page or in the Schedule in the Terrorism Premium Endorsement. (WC 99 01 20), attached to this policy.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

**(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)**

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 04 19 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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.**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 09 03 03 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN: 

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 09 06 06 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 12 06 01 ( D)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 Six (Conditions), Condition A. **Inspection**, Condition D. **Cancellation** and Condition E. **Sole Representative** of the policy are replaced by these four Conditions.

**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.

**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 and to the broker or the agent of record advance written notice stating when the cancellation is to take effect.

**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 more than 60 days.

**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 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 Director has determined that we no longer have adequate reinsurance to meet our needs.
- **f.** The Director has determined that continuation of coverage could place us in violation of the laws of Illinois.

**5.** Our notice of cancellation will state our reasons for canceling.

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 12 06 01 ( D)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

**Nonrenewal**

**1.** We may elect not to renew the policy. If we fail to give 60 days notice, the policy will automatically be extended for one year. The nonrenewal notice will be sent to your last known mailing address. We will maintain proof of mailing of the notice to not renew the policy. An exact and unaltered copy of such notice will also be sent to the insured's broker, if known, or the agent of record at the last mailing address known by the company.

**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 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.

**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 to give us notice of cancellation.

Part Five (Premium), Section G. **Audit** is replaced by this Section.

**Audit**

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy 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.

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: **07-10-14** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 15 04 01 (A )**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 15 06 01 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **(HHUB-6E81767-4-14)**

# 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 24 03 02 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN: 

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 24 04 01 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# MISSOURI CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT ENDORSEMENT

The premium for the policy may be adjusted by a Missouri Contracting Classification Premium Adjustment factor. The factor was not available when the policy was issued. If you qualify, we will issue an endorsement to show the premium adjustment factor after it is calculated.

DATE OF ISSUE: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 24 06 01 ( B)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 24 06 04 ( A)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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: **07-10-14** ST ASSIGN: 

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 26 06 01 ( C)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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 99 06 46 (00)**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

# 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**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

## 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: **071014**

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<br>1,000<br>1,500<br>2,000<br>2,500 | See Your Agent/ Broker | $ 5,000<br>10,000<br>15,000<br>20,000<br>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<br>1,000<br>1,500<br>2,000<br>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: **071014**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION**
**AND**
**EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

## 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: **07-10-14**

**W12N3C01**

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

## 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: **07-10-14**

TRAVELERS
ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

## 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: **071014**

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: _____

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.

# CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: **(HHUB-6E81767-4-14)** Effective Date of Policy: **06-29-14**

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: **(HHUB-6E81767-4-14)**

# 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:
**SPECIALTY MEDICAL SYSTEMS, INC**
**1911 BROADWAY**
**KANSAS CITY MO 64108**

POLICY NUMBER: **(HHUB-6E81767-4-14)**
EFFECTIVE DATE: **06-29-14**

# 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<br>**Reasons/Basis:** | **+.00** |
| **B.** Return to Work Program<br>**Reasons/Basis:** | **+.00** |
| **C.** Commitment to use telephone reporting<br>**Reasons/Basis:** | **+.00** |
| **D.** Safety Program<br>**Reasons/Basis:**<br>**FORMAL SAFETY AND TRAINING PROGRAMS IN PLACE PER RISK CONTROL REPORT** | **-.02** |
| **E.** Employee Selection, Training, Supervision<br>**Reasons/Basis:** | **+.00** |
| **Total Schedule Rating Factor** | **-.02** |

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

**POLICY NUMBER: (HHUB-6E81767-4-14)**

**SPECIALTY MEDICAL SYSTEMS, INC**
**1911 BROADWAY**
**KANSAS CITY MO 64108**

# MISSOURI CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

The Contracting Classification Premium Adjustment Program is applicable to qualifying employers engaged in contracting operations.

A premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. To determine a possible credit, please return the completed premium credit application, as set out on the reverse side of this letter, to:

NCCI
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

NCCI will advise us of any premium credit applicable.

**If NCCI does not receive this application within 180 days after policy effective date, your premium calculation will not reflect any possible premium credit.**

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state of Missouri, report the total payroll (excluding overtime pay), and the corresponding total number of hours worked for the third calendar quarter (July, August, September) of the year preceding the policy effective date as reported to taxing authorities.

Note #1: If you did not engage in contracting operations for the complete quarter, then the last complete calendar quarter prior to the effective date of your workers compensation policy should be used.

Note #2: If you are a new business (no prior operations) or there was no complete quarter of operations prior to the policy effective date, submit the requested information for the first complete calendar quarter following the effective date of your workers compensation policy when available.

Note #3: In the absence of specific records for salaried employees, you should assume that each individual worked forty (40) hours per week.

Please preserve your payroll records that formed the basis for this declaration, because we will be required to verify the reported information in order for any premium credit to be applied.

Thank you for your cooperation.

Sincerely,

## CONTRACTING CLASSIFICATION – PREMIUM CREDIT APPLICATION

**INSURED:** SPECIALTY MEDICAL SYSTEMS, INC

**POLICY NUMBER:** (HHUB-6E81767-4-14) **POLICY EFFECTIVE DATE:** 06-29-14

**CARRIER:** THE TRAVELERS INSURANCE COMPANIES

**NOTE:** Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and application is signed, it cannot be processed. Contact your agent or carrier if assistance.

| CLASSIFICATION | CODE | TOTAL WAGES PAID | TOTAL HOURS WORKED |
|---|---|---|---|
| **Example: Electrical Wiring** | **5190** | **$8,000** | **520** |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Noncontracting Classifications:** | | | |
| | | | |
| | | | |

**The foregoing is based on actual wages** (excluding overtime pay) **and hours worked as reflected in our payroll records for the complete calendar quarter.**

**Complete Calendar Quarter (please circle one):**

**1st (1/1–3/31)** **2nd (4/1–6/30)**

**3rd (7/1–9/30)** **4th (10/1–12/31)**

**Calendar Year:** _____

**SIGNATURE:** _____ **POSITION:** _____ **DATE**: _____

DATE OF ISSUE: **07-10-14**

# 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<br>**FARMINGTON CASUALTY COMPANY** | | | |
| Business address | **P.O. BOX 3205**<br>**NAPERVILLE, IL 60566-7205** | | |
| Business phone | **(800) 238-6225** | | |
| Effective date | **06-29-14** | Termination date | **06-29-15** |
| Policy number | **(HHUB-6E81767-4-14)** | Employer's FEIN | **481108590** |

*ICPN 10/11* *Printed by the authority of the State of Illinois.*

**W12P1O12**

# COMPENSACION A LOS TRABAJADORES

es un sistema de beneficios que por ley se provee a la mayoría de trabajadores que se han enfermado o accidentado en el trabajo. Los beneficios son pagados por lesiones que son causadas en parte o completamente por el trabajo del trabajador. Esto puede incluir el agravante o una condición pre-existente, lesiones causadas por uso repetitivo de una parte del cuerpo, ataques cardiacos, o cualquier otro problema físico causado por el trabajo. Los beneficios son pagados sin importar la causa.

## SI USTED SUFRE DE UNA LESION O ENFERMEDAD RELACIONADA AL TRABAJO, USTED DEBE TOMAR LAS SIGUIENTES MEDIDAS:

1. **OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los sintomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.
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.

   Si usted tiene que faltar al trabajo para recuperarse de la lesión o enfermedad, usted tiene derecho a recibir pagos semanales y atención médica necesaria hasta que este capacitado para regresar a trabajar y que el trabajo este de acuerdo a sus capacidades.

   Es contra la ley que el empleador moleste, despida o se niegue a reemplear o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.
4. **MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

   Los trabajadores accidentados tienen derecho para volver a abrir su caso dentro de 30 meses después que la Comisión haya otorgado una decisión y la incapacidad haya incrementado, pero en casos resueltos por una suma global aprobada por la Comisión no pueden volver a abrirse. Unicamente las decisiones aprobadas por la Comisión son obligatorias.

Para mas información, visite la Red de la Comisión de Compensación para Trabajadores o llame a nuestras oficinas:

| | | | |
|---|---|---|---|
| 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 (Sordo): 312/814-2959 |

**LOS EMPLEADORES DEBEN EXHIBIR ESTE AVISO EN UN LUGAR VISIBLE PARA TODOS LOS TRABAJADORES Y LLENAR LA INFORMACIÓN REFERENTE A LA COMPAÑIA DE SEGUROS.**

| | | | |
|---|---|---|---|
| Nombre: **FARMINGTON CASUALTY COMPANY** | | | |
| Dirección de la Compañía: | **P.O. BOX 3205**<br>**NAPERVILLE, IL 60566-7205** | | |
| Teléfono de la Compañía: | **(800) 238-6225** | | |
| Fecha efectiva: | **06-29-14** | Fecha de terminación: | **06-29-15** |
| Número de Póliza: | **(HHUB-6E81767-4-14)** | FEIN del Empleador: | **481108590** |

*ICPN 10/11 Impreso por la autoridad del Estado de Illinois.*

**W12P2O12**

**SPECIALTY MEDICAL SYSTEMS, INC**

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

# Workers Compensation Rights and Responsibilities

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

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

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

## WHAT TO DO IF AN INJURY OCCURS ON THE JOB

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

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

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

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

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

## QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

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

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

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

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

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

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

**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.

**www.dol.ks.gov** **KANSAS DEPARTMENT OF LABOR** K-WC 40-A (Rev. 4-13)

**W15P5Q13**

# INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 4-13)

* 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.

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. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.
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 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

**E-mail** _____

# INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 4-13)

* 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. El empleador debe reportar cada accidente de los trabajadores a la División of Compensación de Trabajadores dentro de 28 días de la fecha del accidente, o de la fecha en que el empleador se haya dado cuenta del accidente, cuando el trabajador esté completa o parcialmente incapacitado por lo que resta del día o del turno.
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** _____

## 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: **SPECIALTY MEDICAL SYSTEMS, INC**
Address: **1911 BROADWAY**
**KANSAS CITY MO 64108**

Workers Compensation Carrier
(or third party administrator): **THE TRAVELERS INSURANCE COMPANIES**

Policy #: **(HHUB-6E81767-4-14)** , effective **06-29-14** to **06-29-15**

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**

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 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.

**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 for the year immediately preceding the injury, 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.

**The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by P.L. 101-336, The Americans With Disability Act. Alternative format available upon request.**

# 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/insurer 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.

### *Workplace Safety*

The Missouri Department of Labor offers free safety services to employers through its Missouri Workers' Safety Program (MWSP) to help employers reduce occupational injuries and workers' compensation costs. Call 573-751-3403 or e-mail mwsp@labor.mo.gov for more information or for a registry of certified consultants and safety engineers. **Employees are urged to report all safety hazards or concerns to the Occupational Safety and Health Administration (OSHA) at 816-483-9531 or 314-425-4249.**

### *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 is a class D felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

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

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

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

DIVISION OF WORKERS' COMPENSATION

**División de Indemnización para el Trabajador de Missouri**
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

**Compañía aseguradora, Adminstrador de Terceros, Compañía de Servicios o Persona designada si es autoasegurada**

Nombre **THE TRAVELERS INSURANCE COMPANIES**

Dirección **P.O.BOX 2928 (WC) OVERLAND PARK, KS 66201-9833**

Teléfono **(800) 238-6225**

**INFORMACIÓN PARA EL EMPLEADO**

La División de Indemnización para el Trabajador de Missouri (DWC) administra programas para los trabajadores que se hayan lesionado en el trabajo o que presenten una enfermedad laboral derivada de su trabajo o que hayan desarrollado durante su trabajo. Los Jueces del Derecho Administrativo de la División tienen autoridad para aprobar acuerdos u otorgar indemnizaciones después de una audiencia en relación con el derecho que un empleado lesionado tenga a recibir beneficios.

***Medidas que tomar cuando haya un accidente en el trabajo***

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

_____, _____.
*(representante del empleador)* *(teléfono)*

***No hacerlo puede impedir que reciba beneficios***

2. **Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).**
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

**Ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.**

***Beneficios para empleados lesionados***

**Atención Médica:**

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, **inmediatamente póngase en contacto con su empleador o su aseguradora.** El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

**Pago de salarios perclidos:**

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima méjoria médica"; de esto, lo que ocurra primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal.**

**Beneficios por discapacidad permanente:**

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

**Beneficios para los sobrevivientes:**

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerales por hasta $5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

**Según lo exige la Ley de Derecho Público 101-336, la Ley para Estadounidenses con Discapacidades, la División de Indemnización para el Trabajador no discrimina a las personas que tengan alguna discapacidad. Disponemos de otros formatos previa solicitud.**

# Ley sobre Indemnización al Trabajador

## *Funciones y responsabilidades de los empleadores y los empleados*

## INFORMACIÓN PARA EL EMPLEADOR

Salvo algunas excepciones, se exige que todos los empleadores que tengan cinco empleados o más, así como los empleadores de la industria de la construcción con uno o más empleados, aseguren su responsabilidad de indemnización por accidentes laborales ya sea al adquirir una póliza o al conseguir autoridad para tener un autoseguro. El seguro de indemnización por accidentes laborales otorga beneficios a aquellos trabajadores que resulten lesionados en el trabajo. También se exige que los empleadores publiquen esta notificación en el lugar de trabajo para que los empleados la vean. El Artículo 287.127 de RSMo exige este cartel que se encuentra disponible para los empleadores y compañías aseguradoras sin costo alguno si se comunican a la División al 800-775-Comp.

***Medidas que hay que tomar cuando haya una lesión***

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador **en un lapso de 30 días** a partir de que se sepa de la lesión.
3. Pague los gastos medicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o medico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
4. Para más información sobre la responsabilidad y el seguro en relación con el Programa de Indemnización por Accidentes Laborales, ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

***Seguridad en el lugar de trabajo***

El Departamento del Trabajo de Missouri ofrece a los empleadores servicios gratuitos de seguridad mediante su Programa de Seguridad para los Trabajadores de Missouri (MWSP) con el fin de ayudarles a reducir las lesiones laborales y los gastos de indemnización por accidentes en el trabajo. Llame al 573-751-3403 o envíe un correo electrónico a mwsp@labor.mo.gov para obtener más información o para solicitar un registro de los asesores certificados y los ingenieros de seguridad. **Se exhorta a los empleados a que reporten todo riesgo o duda de seguridad a la Administración de Seguridad y Salud Ocupacional (OSHA) al 816-483-9531 o al 314-425-4249.**

***Fraude/Incumplimiento***

**Fraude por parte del empleado –** reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta $10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una intracción posterior se considera delito grave clase C.

**Fraude por parte del empleador –** falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta $10,000. Una infracción posterior se considera delito grave clase C.

**Fraude por parte de la compañía aseguradora –** rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta $10,000 o el doble del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

**Incumplimiento por parte del empleador –** no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta $50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de $50 a $1,000 o con encarcelamiento, o multa y encarcelamiento.

NAMED INSURED: SPECIALTY MEDICAL SYSTEMS, INC

POLICY NUMBER: (HHUB-6E81767-4-14)

EFFECTIVE DATE: 06-29-14

# GUNTHER OPERATOR:

# MANUALLY INSERT 1 COPIES OF THE FLORIDA OVERSIZED POSTING NOTICES

# W09P1 — (ENGLISH)

# AND

# W09P2 — (SPANISH)

## ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER—Name: SPECIALTY MEDICAL SYSTEMS, INC
1911 BROADWAY
Address: KANSAS CITY MO 64108

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES
Address: (VARIES BY LOCATION)

AGENT—Name: LOCKTON COMPANIES LLC

POLICY NUMBER: (HHUB-6E81767-4-14)

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:** SPECIALTY MEDICAL SYSTEMS, INC

**Policy Number:** (HHUB-6E81767-4-14)

**Effective Date:** 06-29-14

MANUAL INSERT INFORMATION

MANUAL INSERT INFORMATION

EMPLOYER – Name: SPECIALTY MEDICAL SYSTEMS, INC
Address: 1911 BROADWAY
KANSAS CITY MO 64108

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address:

AGENT – Name: LOCKTON COMPANIES LLC
POLICY NUMBER: (HHUB -6E81767-4-14)
Eff. Date: 06-29-14
Exp. Date: 06-29-15

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:
Address:

CARRIER – Name:
Address:

AGENT – Name:
POLICY NUMBER:
Eff. Date:
Exp. Date:

EMPLOYER – Name: SPECIALTY MEDICAL SYSTEMS, INC
Address: 1911 BROADWAY
KANSAS CITY MO 64108

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address:

AGENT – Name: LOCKTON COMPANIES LLC
POLICY NUMBER: (HHUB -6E81767-4-14)
Eff. Date: 06-29-14
Exp. Date: 06-29-15

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:
Address:

CARRIER – Name:
Address:

AGENT – Name:
POLICY NUMBER:
Eff. Date:
Exp. Date:

TRAVELERS

ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY OVERPRINT PAGE**

POLICY NUMBER: **(HHUB-6E81767-4-14)**

INSURED'S NAME: **SPECIALTY MEDICAL SYSTEMS, INC**

POLICY EFFECTIVE: **06-29-14** POLICY EXPIRY: **06-29-15**

| | | |
|---|---|---|
| NEW/RENEWAL: **N** | SOLICITOR: | SAI: **9781C9085** |
| RESPONSIBILITY: **H** | MSI: | SIC CODE: **3841** |
| PAYMODE/ DIRECT BILL CODE: **B** | AUDIT FREQUENCY: **A** | REINSURANCE: |
| WATCH FILE: **0** | SURVEY CODE: **0** | NEG COMM: **.0500** |
| PROGRAM CODE: **SEQ** | NBR OF POL IN SAI: | AGENCY BILL: **N** |
| AMS BINDER #: | PARENT FEIN: **481108590** | 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 |
|---|---|---|---|---|---|---|
| **FL** | **HJUB** | **3685** | **IA** | **HEUB** | | **3685** |
| **IL** | **HFUB** | **8742** | **KS** | **HKUB** | | **3685** |
| **KY** | **HHUB** | **3685** | **MO** | **HHUB** | * | **3685** |
| **ND** | **HJUB** | **8742** | **NE** | **HKUB** | | **3685** |
| **OH** | **HJUB** | **8742** | | | | |

**COMMISSION/INSTALLMENT SUMMARY**

| ACCT MO | EFF DATE | GROSS AMT | | COMM RATE |
|---|---|---|---|---|
| 07-14 | 06/29/14 | 3.00 | #(D3) | .0000 |
| 07-14 | 06/29/14 | 185.00 | CR | .0000 |
| 07-14 | 06/29/14 | 1516.00 | #(62) | .0000 |
| 07-14 | 06/29/14 | 123.00 | #(43) | .0000 |
| 07-14 | 06/29/14 | 1223.00 | CR | .0000 |

OFFICE: **ST LOUIS 184**
PRODUCER: **LOCKTON COMPANIES LLC BXY10** RATER: **ST**
ISSUE DATE: **07-10-14** CHANGE EFFECTIVE DATE: **06-29-14**

WUNT6H96

POLICY NUMBER: **(HHUB-6E81767-4-14)**

| | | | |
|---|---|---|---|
| **07-14** | **06/29/14** | **35700.00** | **.0500** |

| | | |
|---|---|---|
| **TOTALS** | **$** | **35934.00** |

**#(D3) ILLINOIS INDUSTRIAL COMMISSION FUND**
**#(43) KENTUCKY SPECIAL FUND ASSESSMENT**
**#(62) MISSOURI WORKERS COMPENSATION SECOND INJURY FUND SURCHARGE**