INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270 (Revisado 6-12)

ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE MAYO 15, 2011

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) 30 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, 20 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 SEE ATTACHED ENDORSEMENT

Dirección 7300 WEST 110 STREET

OVERLAND PARK, KS 66210

Persona de Contacto _____

Teléfono ( ) 800-327-3636

Correo electrónico _____

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/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company SEE ATTACHED ENDORSEMENT

Address 7300 WEST 110 STREET
OVERLAND PARK, KS 66210

Contact Person

Phone ( ) 800-327-3636

Email

IMPORTANT NOTICE TO POLICYHOLDERS - TERRORISM RISK INSURANCE ACT

On December 26, 2007, legislation was enacted extending the federal Terrorism Risk Insurance Act of 2002, as amended (TRIA or the "Program"), until December 31, 2014. In accordance with TRIA , we must make coverage for "certified acts of terrorism" available under your policy. Previously, TRIA defined "certified acts of terrorism" to include only acts of terrorism committed by an individual or individuals "acting on behalf of any foreign persons or foreign interest. " This was commonly referred to as "foreign terrorism". Coverage for "domestic terrorism", or acts of terrorism perpetrated by persons with no ties to foreign persons or interest, was provided in accordance with the terms and conditions of your policy, unless specifically excluded. On policies effective on or after December 26, 2007, TRIA no longer distinguishes between foreign and domestic terrorism in its definition of "certified acts of terrorism". As a result, a "certified act of terrorism" now includes both foreign and domestic terrorism. The actual coverage provided by your policy for "certified acts of terrorism" is limited by the terms and conditions of your policy and/or applicable rules of law.

For the duration of the Program, "certified acts of terrorism" will be defined in our policies as follows:

> A "certified act of terrorism" means any act certified by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General of the United States, to be an act of terrorism pursuant to TRIA. The criteria contained in TRIA for a "certified act of terrorism" include the following:
>
> 1. The act resulted in insured losses in excess of $5 million in the aggregate, attributable to all types of insurance subject to TRIA; and
> 2. The act resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and
> 3. The act is a violent act or an act that is dangerous to human life, property or infrastructure and is committed by an individual or individuals acting 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.

Terrorism coverage made available in our policies is partially reinsured by the United States Department of the Treasury (the "Treasury") under a formula established by TRIA. Under this formula, the federal share equals 85% of that portion of insured losses that exceed the applicable insurer deductible. However, if aggregate insured losses attributable to "certified acts of terrorism" under TRIA exceeds $100 billion in a Program Year (January 1 through December 31) the Treasury will not make any payment for any portion of such losses that exceeds $100 billion.

If aggregate insured losses attributable to certified acts of terrorism under TRIA exceed $100 billion in a Program Year (January 1 through December 31) and we have met our insurer deductible under TRIA, we shall not be liable for the payment of any portion of such losses that exceeds $100 billion and, in such case, insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

The premium attributable to coverage for "certified acts of terrorism" is set forth as follows. The charge for terrorism is either shown in Item 4 of the Information Page or on the Schedule. The rate for terrorism will apply as of the effective date of your policy or the anniversary rating date if different from the effective date.

The terrorism rates are subject to change at any time based on state regulatory action.

IMPORTANT MESSAGE TO WORKERS' COMPENSATION POLICYHOLDERS IN WEST VIRGINIA

When notified of a work related injury, please complete the WC-2 form (West Virginia Workers' Compensation Employer's Report of Occupational Injury or Disease) and contact The Hartford Loss Connect Service to report the claim. Prompt reporting allows The Hartford to properly investigate and manage your claim, and make all State filings on your behalf.

In addition, please provide form WC-1 (West Virginia Workers' Compensation Employee's and Physicians' Report of Occupational Injury or Disease) to the injured employee for completion, with instruction to present to the Initial Healthcare Provider. A copy of this form should be sent to The Hartford Claim Office.

When notified of a work related inhalation exposure, please provide form OIC-WC-10P (West Virginia Workers' Compensation Employees' Report of Occupational Pneumoconiosis) to the injured employee for completion. A copy of the form should be sent to The Hartford Claim Office.

All State forms may be accessed from the State of West Virginia's Offices of The Insurance Commissioner. The forms can be accessed via the State's website: www.wvinsurance.gov or by phone at 304-558-3386 or Toll Free 1-888-TRY-WVIC (1-888-879-9842).

Forms with Brickstreet Insurance information or letterhead should not be used when filing claims with The Hartford. Use of these forms may create delays in State reporting, benefit payments, and other claim management activity.

Please contact *The Hartford Loss Connect Service* @ 1-800-327-3636 to file your workers' compensation claims.

MAINTAINING YOUR RECORDS FOR AUDIT PURPOSES

WHAT IS A PREMIUM ADJUSTMENT?

When your Workers' Compensation policy was issued you paid a deposit premium based on the nature of your business and estimates of your payroll. At the end of the policy period, we conduct an audit to compare the estimates against the actual figures and operations. Based on this comparison an adjustment is made. If the actual premium is less than what you already have paid, a refund will be made. If it's more, you will be billed for the difference. These adjustments are subject to any minimum premiums that apply.

HOW WILL THE PREMIUM ADJUSTMENT BE MADE?

On smaller, less complex operations we may ask you to provide the information by mail or telephone. If we do, we will provide the necessary forms for you to complete.

On larger, more complex operations one of our Premium Auditors will contact you for an appointment. You will be contacted either by telephone or mail. If directed, the auditor will contact your accountant to obtain as much information as possible and contact you at a later time for additional information that may be needed.

BASIS OF PREMIUM

Remuneration (Payroll) in most states, includes:

Payment of:	Wages, bonuses, commissions, overtime,* sick pay, vacation pay,* tool allowances, contributions to individual retirement accounts, employee contributions to employee benefit plans.
Payments on basis of:	Piece work, incentive plans, profit sharing.
The value of:	Housing furnished to employees,* meals furnished to employees,* store certificates, merchandise and other dollar substitutes.

Remuneration does not include:

a. Employer contributions to a group insurance or pension plan other than statutory plans of insurance.

b. Special awards for individual inventions or discoveries.

c. Overtime.*

Subcontractors. In the absence of other insurance, most state laws hold a contractor responsible for injuries to employee of subcontractors. At the time of audit Certificates of Insurance must be available for subcontractors with employees, in order to avoid payment of premium.

Independent Contractors, without employees, whose duties closely resemble those of an employee, will be considered your employee with the appropriate premium charged.

The actual working relationship between you and the Independent Contractor is examined. Items such as, but not limited to: whether the work performed is an integral part of your operations, whether you have the right to control the details of the work, the method of payment, who supplied the materials used, does the person regularly work for others, whose regulatory authority did person operate under, whether the person is involved in a separate and distinct business offering the same services to the public.

RECORDS

As part of the policy conditions, we are allowed to examine your financial books and records to determine actual exposures and operations. We would appreciate your cooperation in making the needed records available for the auditor's inspection.

What Records Will Be Needed?

The records needed will vary. In most cases, the Premium Auditor will be able to obtain the necessary audit data from two or more of the following records: Journals, Ledgers, State and Federal Tax Reports, Individual Earning Cards, Checkbooks and Contracts.

How You Should Keep Your Records

By maintaining your payroll records in accordance with the following guidelines, you might reduce your insurance costs.

Overtime. In most states, the amount paid in excess of straight time pay can be deducted if it can be verified in your records. You must maintain your records to show pay separately by employee and in summary by classification of work.

***Division of an employee's payroll** to more than one classification is not allowed in most states.

Exception: For construction, erection or stevedoring operations the payroll of an employee may be allocated to each type of work performed if proper records are kept. Your records must show the number of hours and amount of payroll for each type of work. If you do not keep such a breakdown, the full salary must be charged to the highest rated classification to which the employee is exposed

Executive Officers in most states are considered employees of their corporation and included in the computation of premium. Their remuneration is assigned without division to the actual operation in which they are engaged. If their duties are the same as those of a worker, foreman or superintendent, their payroll is assigned to the classification that develops the highest payroll. Minimum and maximum payrolls apply to executive officers.

Automated Records. If your records are automated or you plan to automate in the near future you can obtain maximum benefits by setting up your records to include insurance requirements. Our Premium Auditor will be pleased to assist you in setting up your records. Contact your Hartford Representative if you would like this assistance.

NOTE: The contents of this publication are not intended to supersede any definitions or conditions of your policy, the Workers' Compensation Law or any legal rulings.

****Your state may have specific rules or exceptions. Please contact your Hartford Representative for details that may apply and answer questions you may have.***

IMPORTANT NOTICE TO OUR OREGON POLICYHOLDERS

OREGON INSURANCE GUARANTY ASSOCIATION SURCHARGE

Most insurers doing business in Oregon participate in the Oregon Insurance Guaranty Association (OIGA). In the event an insurer fails, the Association settles unpaid claims on behalf of consumers. Oregon law requires that policies be surcharged directly to recover the costs of handling those claims.

If your policy is surcharged, the term "OIGA Surcharge" along with an indicated dollar amount will be displayed with the statement of your surcharge.

If you have any questions, please contact your Hartford agent, broker or representative.

Policy Number 37 WB BN3284 Policy Effective Date 10/01/13

WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

Dear Hartford Insured,

Re: An Important Message to Workers Compensation Policyholders

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense.

An effective loss prevention/loss control program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations.

As a service to you, our valued customer, the Loss Control Department of The Hartford in cooperation with your independent agent, can assist you in establishing loss control strategies. If you would like assistance, please complete and return to us the reply portion of this brochure, or contact your independent agent.

Services Available
The following is a description of some of the services that we provide. The types of services that may be appropriate for your business depend upon the nature and size of your operations and the specific loss control services you have requested. The cost of loss control services may or may not be a part of your insurance premium. This depends on the extent of the requested services, agreements stated in your insurance policy and program, and statutory regulations that may require us to provide loss control services.

1) **Reference Materials** – Information about loss control topics that can be provided or made available to you to help you to enhance your loss control program.

2) **Telephone Consultation** – We can hold a teleconference with you to help you to evaluate your loss control program, identify areas for improvement, and recommend ways to implement such improvements.

3) **Onsite Consultation** – This consists of visiting your premises and helping you to assess and remedy your loss control needs onsite. This level of service is usually only appropriate for larger, higher hazard operations. The following are examples of some of the services that could be provided onsite:

- A review of your safety program to determine its adequacy and recommend modifications to that plan where needed.
- Specific hazard evaluations, including ergonomics, industrial hygiene or material handling.
- An initial survey and evaluation to address potential safety and health hazards.
- Consultation to help management establish a comprehensive loss prevention Program.
- Periodic summaries of accidents and analysis of causes.
- Follow-up visits to check on progress and to provide continuing assistance when required.

A Word About OSHA

The Occupational Safety and Health Act of 1970 and similarly approved State Plans require employers to provide their employees with safe and healthful places to work. The Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor and similar State agencies enforce the regulations and apply penalties (civil and criminal) for non-compliance.

New standards have been developed, and through application and interpretation, standards change. You should make yourself aware of the standards that are applicable to your operations, and assure yourself that reasonable efforts are made to be in compliance. Copies of the standards are available through most libraries, or can be obtained through OSHA or the U.S. Government Printing Office.

You should know that neither The Hartford, nor any other party, can fulfill your obligations under the Law. Questions related to your legal obligations should be referred to your legal counsel.

Some Safety Reminders from The Hartford:

Have you considered:

- The need to formalize your safety efforts to assure compliance and document your efforts?
- The need to acquire Material Safety Data Sheets on all hazardous materials and the need for training on appropriate safety measures for your employees?
- Requirements for record keeping of injuries, illnesses, and exposure to hazardous substances?
- Assessing each job task to determine hazards and needed controls?
- Measuring each exposure to hazardous substances to determine the need for control or personal protective equipment?
- What mechanisms are in place to periodically verify that exposure controls (guards, ventilation systems, etc.) are still in place and working?
- What specific training your employees and your supervisors need to avoid hazards in the workplace?
- What specific OSHA standards apply to your business?

- What mechanism exists to promptly investigate all accidents and ‘near-misses’ to limit the chance of another occurrence?
- The financial impact an injury or illness has on your business?
- What resources are available to you to help prevent accidents and illnesses?

Thank you for your business.

Sincerely,

The Hartford’s Loss Control Department

THIS BROCHURE IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR A COMPLETE ON-SITE SAFETY INSPECTION CONDUCTED BY A QUALIFIED LOSS CONTROL SPECIALIST. READERS ARE ENCOURAGED TO HAVE SUCH AN INSPECTION CONDUCTED BOTH TO PROMOTE WORKPLACE SAFETY AND TO COMPLY WITH APPLICABLE LAW.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, EITHER TELEPHONE OR MAIL THIS FORM TO YOUR HARTFORD AGENT OR NEAREST OFFICE OF The HARTFORD

NOTICE TO ARKANSAS POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain accident prevention services at no additional cost as required by ARK. Code Ann. §11-9-409(D) and Rule 32. If you would like more information, call The Hartford's Loss Control Department, One Hartford Plaza, HO-GL-19-1, Hartford, CT 06155 at 1-860-547-7761. If you have any questions about this requirement, call the Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

NOTICE TO CALIFORNIA POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain occupational safety and health loss control consultation services as required by the California Labor Code, §6354.5, at no additional charge. If you would like more information call The Hartford's Loss Control Division at 1-860-547-7761 for occupational safety and health loss control consultation services.

California Workers Compensation insurance policyholders may register comments about the insurer's loss control consultation service by writing to:

State of California
Department of Industrial Relations
Division of Occupational Safety and Health
P.O. Box 420603
San Francisco, California 94142

NOTICE TO PENNSYLVANIA POLICYHOLDERS

The Hartford maintains and provides accident and illness prevention services as required by the nature of the policyholder's business or its operation, in accordance with the Pennsylvania Workers' Compensation Act. For more information about these services contact your Hartford Agent or nearest office of The Hartford.

NOTICE TO TEXAS POLICYHOLDERS

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

The Hartford is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact The Hartford at 1-860-547-7761 and email contactlosscontrol@thehartford.com for accident prevention services or 1-877-889-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

To The Hartford's Loss Control Department:

Yes – I am interested in obtaining information concerning:

General Topics
___ Accident Analysis
___ Accident Investigations
___ Establishing a Loss Control Program
___ Hazard Recognition
___ Safety Committees

Business Continuity
___ Business Travel Safety
___ Contingency Planning Overview
___ Emergency/Disaster Response
___ Emergency Evacuation Drills
___ Emergency Preparedness Planning

Construction
___ Construction Site Consultation
___ Construction Equipment Hazards
___ Hazard Communication
___ Ladders & Scaffolds
___ Trenching & Evacuation
___ Fall Protection

Ergonomics
___ Back Injury Prevention
___ Computer Workstation
___ Cumulative Trauma Disorders
___ Ergo Train-the-Trainer
___ Telecommuting

Industrial Hygiene
___ Hazard Communication
___ Industrial Hygiene (general)
___ Indoor Air Quality
___ Noise Exposures
___ Respiratory Protection

Property
___ Automatic Sprinkler System
___ Flammable Liquids
___ Fire Prevention and Protection
___ Fire Drill and Evacuation
___ Hot Work Permit Program

Transportation
___ 3-D Driver Training
___ Driving Defensively
___ Fleet Newsletter
___ Guide to Successful Driver Mgmt
___ School Bus Driving Tips

Workers' Compensation
___ Bloodborne Pathogens
___ Drug Screening
___ Machine Safeguarding
___ Return to Work Programs
___ Slip and Falls

Other Topics
___ Business Risk Management
___ General Liability Investigations
___ Product Liability Programs
___ Safety Training
___ Security/Terrorism

Name _____

Company _____ **Policy #** _____

Address _____

City & State _____ **Zip Code** _____

Email Address: _____ **Telephone** _____

For more information on the above, you can visit our website at
https://www.thehartford.com/losscontrol
Or you may forward your request to:
Fax line: 1-860-723-4459
Or mail to:
The Hartford Financial Services Group
Loss Control Department
One Hartford Plaza HO-GL-19-1
Hartford, CT 06155

IMPORTANT NOTICE

ALABAMA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Alabama Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.9%	0.6%	0.5%	0.4%	0.4%	0.3%	0.2%
( )	$ 200	1.7%	1.3%	1.0%	0.8%	0.7%	0.4%	0.3%
( )	$ 300	2.4%	1.8%	1.5%	1.3%	1.0%	0.7%	0.5%
( )	$ 400	3.1%	2.3%	1.9%	1.6%	1.3%	0.9%	0.6%
( )	$ 500	3.6%	2.8%	2.3%	1.9%	1.6%	1.1%	0.8%
( )	$ 1,000	5.6%	4.4%	3.8%	3.1%	2.6%	1.8%	1.3%
( )	$ 1,500	6.9%	5.5%	4.6%	3.9%	3.3%	2.3%	1.7%
( )	$ 2,000	7.8%	6.3%	5.4%	4.5%	3.8%	2.7%	2.0%
( )	$ 2,500	8.6%	7.0%	6.0%	5.1%	4.3%	3.0%	2.3%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

IMPORTANT NOTICE

MONTANA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Montana Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to medical and indemnity claims or medical only claims paid under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

MEDICAL AND INDEMNITY PER CLAIM

		A	B	C	D	E	F	G
( )	$ 1,000	4.3%	3.3%	2.8%	2.3%	2.0%	1.3%	0.9%
( )	$ 2,000	6.4%	5.1%	4.3%	3.6%	3.0%	2.1%	1.6%
( )	$ 2,500	7.2%	5.7%	4.9%	4.2%	3.5%	2.5%	1.8%
( )	$ 5,000	10.6%	8.5%	7.4%	6.4%	5.4%	4.0%	3.0%
( )	$ 10,000	15.4%	12.8%	11.2%	9.9%	8.5%	6.6%	4.9%

MEDICAL PER CLAIM

		A	B	C	D	E	F	G
( )	$ 500	2.8%	2.1%	1.8%	1.5%	1.2%	0.8%	0.6%
( )	$ 1,000	4.1%	3.2%	2.7%	2.2%	1.8%	1.3%	0.9%
( )	$ 1,500	5.1%	4.0%	3.3%	2.8%	2.3%	1.6%	1.2%
( )	$ 2,000	5.9%	4.7%	3.9%	3.3%	2.8%	2.0%	1.4%
( )	$ 2,500	6.6%	5.2%	4.4%	3.7%	3.1%	2.2%	1.6%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office:
Address:

IMPORTANT NOTICE

NEW YORK WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New York Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 100	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
[ ]	$ 200	0.3%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
[ ]	$ 300	0.4%	0.3%	0.3%	0.3%	0.2%	0.2%	0.1%
[ ]	$ 400	0.5%	0.5%	0.3%	0.3%	0.3%	0.2%	0.2%
[ ]	$ 500	0.6%	0.5%	0.4%	0.4%	0.3%	0.3%	0.3%
[ ]	$1,000	1.1%	1.0%	0.8%	0.7%	0.6%	0.5%	0.5%
[ ]	$1,500	1.6%	1.4%	1.1%	1.0%	0.9%	0.7%	0.6%
[ ]	$2,000	2.1%	1.8%	1.4%	1.3%	1.2%	0.9%	0.8%
[ ]	$2,500	2.4%	2.2%	1.7%	1.5%	1.4%	1.1%	1.0%
[ ]	$5,000	4.4%	3.9%	3.2%	2.8%	2.6%	2.0%	1.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to:
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

Michigan Workers' Compensation
Managed Care Premium Credit Qualifications

This form attests to your agreement to implement and/or continue the controls checked below as a part of your organization's regular operations. By signing this form, you agree to continue the activities you have checked or notify us of your intent to discontinue such practices.

Please check those that apply:

[ ] You agree to use an approved program to return recuperating employees to work on some form of restricted work status (once authorized by a physician), until the employee can resume full employment duties. (5% credit)

[ ] You agree to report at least 80% of all workers' compensation claims within 3 working days of occurrence by using The Hartford's designated toll free telephone number. (10% credit)

[ ] You agree to conduct an injury review or accident investigation following the occurrence of a claim. (5% credit)

[ ] You agree to cooperate with managed care procedures initiated by The Hartford to direct injured employees to appropriate medical treatments, physical therapy, vocational therapy, and/or other processes deemed necessary to achieve maximum medical improvement. **Note: After 10 days from the inception of medical care, the injured employee has the right to be treated by the provider of their choice, pursuant to MCLA 418.315(1). The employer can not force injured employees to use its Designated Medical Provider after 10 days from the inception of medical care, rather it must encourage employees continued use of such services.** (10% credit)

Subject to a maximum total of 25% credit.

You also agree that The Hartford has the right to inspect your records and/or workplace(s) to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Insured's Signature: _____

Title: _____ Date: _____

Company: _____

Policy Number: 37 WB BN3284

Return to
Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE

CHARLOTTE NC 28213

IMPORTANT NOTICE
GEORGIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Georgia Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for Indemnity and/or Medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.7%	0.5%	0.4%	0.4%	0.3%	0.2%	0.1%
( )	200	1.5%	1.0%	0.9%	0.7%	0.5%	0.4%	0.3%
( )	300	2.1%	1.5%	1.3%	1.0%	0.9%	0.5%	0.4%
( )	400	2.6%	1.9%	1.6%	1.3%	1.1%	0.7%	0.5%
( )	500	3.0%	2.3%	1.9%	1.6%	1.3%	0.9%	0.7%
( )	1,000	4.7%	3.7%	3.1%	2.6%	2.1%	1.5%	1.1%
( )	1,500	5.8%	4.6%	3.9%	3.3%	2.7%	1.9%	1.4%
( )	2,000	6.8%	5.4%	4.6%	3.8%	3.2%	2.3%	1.7%
( )	2,500	7.5%	6.0%	5.1%	4.3%	3.7%	2.6%	1.9%

All indemnity and/or medical claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE

CHARLOTTE NC 28213

IMPORTANT NOTICE

NEW MEXICO WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New Mexico Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to bodily injury by accident or disease.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pays all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

			A	B	C	D	E	F	G
( )	$	500	3.9%	3.0%	2.5%	2.0%	1.7%	1.2%	0.9%
( )	$	1,000	6.3%	4.8%	4.2%	3.4%	2.9%	2.0%	1.6%
( )	$	1,500	7.8%	6.1%	5.3%	4.4%	3.7%	2.6%	2.0%
( )	$	2,000	9.1%	7.1%	6.2%	5.2%	4.4%	3.1%	2.5%
( )	$	2,500	10.1%	8.0%	7.0%	5.9%	5.0%	3.6%	2.9%
( )	$	5,000	13.9%	11.2%	9.9%	8.5%	7.3%	5.5%	4.3%
( )	$	10,000	18.9%	15.5%	13.9%	12.2%	10.6%	8.2%	6.6%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Issuing Office THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

IMPORTANT NOTICE

NEBRASKA WORKERS' COMPENSATION INSURANCE
MEDICAL BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Nebraska Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	**$ 500**	3.9%	3.0%	2.5%	2.1%	1.7%	1.1%	0.8%
( )	**$1,000**	6.1%	4.8%	4.0%	3.3%	2.8%	1.9%	1.4%
( )	**$1,500**	7.5%	5.9%	5.1%	4.2%	3.5%	2.4%	1.8%
( )	**$2,000**	8.5%	6.8%	5.8%	4.9%	4.0%	2.8%	2.1%
( )	**$2,500**	9.4%	7.6%	6.5%	5.5%	4.6%	3.2%	2.4%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

IMPORTANT NOTICE

SOUTH DAKOTA WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in South Dakota Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION

MEDICAL AND INDEMNITY

HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 500	4.5%	3.5%	3.0%	2.4%	2.0%	1.3%	0.9%
( )	$ 1,000	6.8%	5.5%	4.6%	3.8%	3.2%	2.1%	1.5%
( )	$ 1,500	8.4%	6.8%	5.7%	4.8%	4.0%	2.7%	2.0%
( )	$ 2,000	9.5%	7.8%	6.6%	5.6%	4.7%	3.3%	2.4%
( )	$ 2,500	10.6%	8.7%	7.4%	6.3%	5.3%	3.7%	2.7%

MEDICAL ONLY

HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 500	4.4%	3.4%	2.9%	2.4%	2.0%	1.3%	0.9%
( )	$ 1,000	6.6%	5.3%	4.4%	3.7%	3.1%	2.1%	1.5%
( )	$ 1,500	8.0%	6.5%	5.5%	4.6%	3.8%	2.6%	1.9%
( )	$ 2,000	9.1%	7.3%	6.2%	5.2%	4.4%	3.0%	2.2%
( )	$ 2,500	10.0%	8.1%	6.9%	5.8%	4.9%	3.4%	2.5%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to

Issuing Office:

Address:

DEDUCTIBLE NOTICE OF ELECTION TO ACCEPT TEXAS WORKERS COMPENSATION BENEFITS

Texas law permits an employer to obtain Workers' Compensation insurance with a deductible. The deductible applies to benefits payable under Texas Workers' Compensation Law. The insurance applies only to benefits in excess of the deductible amount. The deductible applies separately to each accident or disease regardless of the number of people who sustain injury by such accident or disease or as an annual aggregate or as a combination of both. The deductible plans have been explained to me. Premium reductions are determined based on the deductible selected, and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

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

If a deductible amount is desired, please indicate below.

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

1. $ per accident

2. $ annual aggregate

3. $ /$ per accident/annual aggregate

applied to benefits payable under the Texas Workers' Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement

.

(monthly, quarterly or other)

( ) No, I do not want a deductible applied to benefits payable under the Texas Workers' Compensation Law

( ) Yes, I do want a deductible policy, but am unable to obtain for the following reason:

.

WALSWORTH PUBLISHING COMPANY, INC.

Employer Name (print or type)

Date

Signature and Title

37 WB BN3284

Policy Number

WC 66 01 25 Printed in U.S.A.

Process Date: 10/10/13

Policy Expiration Date: 10/01/14

IMPORTANT NOTICE

COLORADO WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY DEDUCTIBLE ELECTION FORM

Recent changes in the Colorado Workers' Compensation Law permit an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only. There are six "Per Claim" deductible options available. They are:

( ) NONE
( ) $ 500
( ) 1,000
( ) 1,500
( ) 2,000
( ) 2,500
( ) 5,000

All medical and indemnity claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you have any questions, or desire one of these deductible amounts to apply to your coverage, please call your Agent for a quote. This offer is valid for thirty days after the effective date of the policy with which this notice is enclosed.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect a medical and indemnity deductible, and your policy is being renewed effective on or after January 1, 1997, you must make your election before the effective date of your policy, otherwise at the next renewal of your policy.

( ) $ 500	**( ) $ 2,500**
( ) $ 1,000	**( ) $ 5,000**
( ) $ 2,000	**( ) Do Not Elect**

( ) $ 2,500 with Aggregate	**( ) Do Not Elect**

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Form WC 66 01 51 A Printed in U.S.A.

Process Date: 10/10/13 **Policy Expiration Date:** 10/01/14

IMPORTANT NOTICE

OKLAHOMA WORKERS' COMPENSATION DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires insurers to offer a medical claim deductible on all Oklahoma Workers Compensation policies. Oklahoma law allows insurers to offer a policy with both medical and indemnity deductible. You may choose a medical deductible only, an indemnity deductible only, or you may choose both a medical and indemnity deductible. You may also choose to reject both.

Five medical deductible options are available. You are not required to select the medical deductible option, but if you choose to exercise this option, you may choose only one deductible amount. Please carefully review the requirements for the medical deductible option outlined below.

Five indemnity deductible options are available. You are not required to select the indemnity deductible option, but if you choose to exercise this option, you may choose only one deductible amount and it must match the medical deductible amount, if you also selected a medical deductible. Please carefully review the requirements for the indemnity deductible option outlined below.

MEDICAL DEDUCTIBLE OPTIONS

The medical claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the medical benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF MEDICAL DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the medical deductible amount to the injured worker or insurer.

If you choose a medical deductible option, the insurer will pay the entire cost of medical bills directly to the provider of the services and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty days of a written demand. If you fail to reimburse the insurer within sixty days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

MEDICAL DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes, I have read the medical deductible information outlined above and want the following medical deductible amount to apply to medical claims under Oklahoma Workers' Compensation Law. I understand that this medical deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

☐ No, I do not want the medical deductible described in this notice.

INDEMNITY DEDUCTIBLE OPTIONS

The indemnity claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the indemnity benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF INDEMNITY DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the indemnity deductible amount to the injured worker or the insurer.

Form 35-4A
Form WC 66 01 55 E Printed in U.S.A.
Process Date: 10/10/13
Policy Expiration Date: 10/01/14

If you choose an indemnity deductible option, the insurer will pay the entire cost of indemnity benefits and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty (60) days of a written demand. If you fail to reimburse the insurer within sixty (60) days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

INDEMNITY DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes I have read the indemnity deductible information outlined above and want the following indemnity deductible amount to apply to indemnity claims under Oklahoma workers compensation law. I understand that this indemnity deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee. I understand that the indemnity deductible amount chosen must match the medical deductible amount chosen, if I also selected a medical deductible.

☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

☐ No, I do not want the indemnity deductible described in this notice.

NAMED INSURED _____
ADDRESS _____
TITLE _____
SIGNATURE _____
DATE _____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part. If you have any questions, please call your agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Form 35-4A
Form WC 66 01 55 E Printed in U.S.A.

IMPORTANT NOTICE

KENTUCKY WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Kentucky Workers' Compensation law permits an employer to purchase workers' compensatio n insurance with a deductible. The deductible is for medical and indemnity benefits only.
Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal.

( )	$ 100	( )	$ 1,500
( )	$ 200	( )	$ 2,500
( )	$ 300	( )	$ 5,000
( )	$ 400	( )	$ 7,500
( )	$ 500	( )	$10,000
( )	$ 1,000		

All claims shall be paid by the company, in such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

ARKANSAS WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Arkansas Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect only one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION

APPLICABLE TO TOTAL LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 1,000	8.3%	6.6%	5.6%	4.7%	3.9%	2.6%	1.9%
[ ]	1,500	10.2%	8.2%	7.0%	5.9%	4.9%	3.3%	2.4%
[ ]	2,000	11.6%	9.5%	8.1%	6.8%	5.7%	4.0%	2.9%
[ ]	2,500	12.8%	10.5%	9.0%	7.6%	6.4%	4.5%	3.3%
[ ]	3,000	13.9%	11.4%	9.8%	8.4%	7.0%	5.0%	3.6%
[ ]	3,500	15.0%	12.3%	10.5%	9.1%	7.7%	5.5%	4.0%
[ ]	4,000	15.9%	13.1%	11.2%	9.7%	8.2%	5.9%	4.3%
[ ]	4,500	16.7%	13.8%	12.0%	10.3%	8.8%	6.3%	4.6%
[ ]	5,000	17.5%	14.5%	12.5%	10.9%	9.2%	6.8%	4.9%

APPLICABLE TO INDEMNITY LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 1,000	1.6%	1.3%	1.2%	1.1%	1.0%	0.8%	0.6%
[ ]	1,500	2.2%	1.8%	1.6%	1.5%	1.3%	1.1%	0.8%
[ ]	2,000	2.7%	2.2%	2.0%	1.9%	1.7%	1.4%	1.0%
[ ]	2,500	3.3%	2.7%	2.4%	2.2%	2.0%	1.7%	1.2%
[ ]	3,000	3.7%	3.1%	2.7%	2.6%	2.2%	1.9%	1.3%
[ ]	3,500	4.1%	3.4%	3.1%	2.9%	2.6%	2.1%	1.5%
[ ]	4,000	4.5%	3.7%	3.4%	3.2%	2.7%	2.3%	1.7%
[ ]	4,500	4.9%	4.0%	3.7%	3.5%	3.0%	2.6%	1.9%
[ ]	5,000	5.2%	4.3%	4.0%	3.7%	3.3%	2.7%	2.0%

APPLICABLE TO MEDICAL LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
☐	$ 1,000	8.1%	6.5%	5.4%	4.5%	3.7%	2.5%	1.8%
☐	1,500	9.7%	7.9%	6.6%	5.6%	4.6%	3.1%	2.2%
☐	2,000	11.0%	8.9%	7.6%	6.4%	5.3%	3.6%	2.6%
☐	2,500	12.1%	9.8%	8.4%	7.1%	5.9%	4.1%	2.9%
☐	3,000	13.0%	10.6%	9.1%	7.7%	6.5%	4.5%	3.3%
☐	3,500	13.7%	11.3%	9.7%	8.2%	6.9%	4.9%	3.5%
☐	4,000	14.4%	12.0%	10.2%	8.7%	7.4%	5.2%	3.8%
☐	4,500	15.1%	12.5%	10.7%	9.1%	7.7%	5.5%	4.0%
☐	5,000	15.7%	13.0%	11.2%	9.6%	8.1%	5.8%	4.2%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office:
Address:

IMPORTANT NOTICE

SOUTH CAROLINA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

South Carolina Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$100	0.6%	0.4%	0.4%	0.3%	0.2%	0.2%	0.1%
( )	$200	1.1%	0.8%	0.7%	0.5%	0.5%	0.3%	0.2%
( )	$300	1.6%	1.2%	1.0%	0.8%	0.7%	0.5%	0.4%
( )	$400	2.0%	1.5%	1.3%	1.1%	0.9%	0.6%	0.4%
( )	$500	2.4%	1.8%	1.5%	1.3%	1.1%	0.7%	0.5%
( )	$1,000	3.8%	3.0%	2.5%	2.1%	1.7%	1.2%	1.0%
( )	$1,500	4.8%	3.8%	3.2%	2.7%	2.3%	1.6%	1.3%
( )	$2,000	5.6%	4.5%	3.8%	3.2%	2.7%	2.0%	1.5%
( )	$2,500	6.3%	5.1%	4.3%	3.7%	3.2%	2.3%	1.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

WORKERS' COMPENSATION SELECTION OF DESIGNATED MEDICAL PROVIDER DISCLOSURE STATEMENT

If you select two Designated Medical Providers meeting the following qualifications, a premium credit will be applied to your policy. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

A qualified Designated Medical Provider is a medical provider, who:

1) **Has a knowledge of work injuries;**
2) **Is knowledgeable of fee schedules;**
3) **Is decisive on medical-maximum-improvement determinations;**
4) **Communicates with you, the employer on such issues as case management and wellness programs;**
5) **Is knowledgeable of the employers operations.**

The names of the providers must be posted and well publicized by you, the employer.

** SIGN AND RETURN **

I am aware of the availability of a premium credit of 2.5%, if I select two qualified Designated Medical Providers. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

Insured Signature _____

Policy Number 37 WB BN3284

Issuing Office THE HARTFORD

Issuing Office Address 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

VIRGINIA DRUG FREE WORKPLACE CREDIT

Name of Employer: WALSWORTH PUBLISHING COMPANY, INC.

Policy Number: 37 WB BN3284

This form attests to your agreement to implement and/or continue to monitor the drug free workplace program you have established throughout the policy period. By signing this form, you agree to continue the following activities or notify us of your intent to discontinue such practices.

- Provide notice to employees and job applicants including a written statement containing the policy on employee drug use, type of drug testing that may be required, actions that can be taken if the test result is positive, consequences of refusing to submit to a drug test, and a list of all drugs for which you will test.

- Educate employees and supervisors about the drug free program in place.

- Require discharge or discipline of any employee whose drug test result is confirmed positive as well as follow-up testing; post-accident testing after every on-the-job accident or injury resulting in loss of work time; pre-employment drug testing; random and reasonable suspicion testing of existing employees; discharge or discipline employees for refusal to submit to drug testing; and maintain compliance with the drug free program throughout the year.

You also agree The Hartford has the right to inspect your records and/or workplaces to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Signature by or on behalf of the Insured: _____

Title: _____ Date: _____

Company: _____

SOUTH CAROLINA - APPLICATION FOR DRUG AND ALCOHOL FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: WALSWORTH PUBLISHING COMPANY, INC.
Policy Number: 37 WB BN3284
Date Program Implemented: _____

This form must be completed by you and returned to your carrier with a copy of applicable documentation as proof of compliance before the premium credit of five percent (5%) can be established and processed. *A program must be certified during each year the employer receives credit.* Failure to do so will remove you from eligibility for this credit.

The following are the four (4) minimum requirements necessary for a qualified employer workplace program. Please check the items below that apply.

( ) 1) Substance Abuse Policy Statement:

Any policy must be designed to help employees who need substance abuse assistance while, at the same time, sending a clear message that the abuse of drugs and alcohol is not compatible with employment in that employer's workplace. The policy statement must evidence both the employer's respect for its employees and the employer's need to maintain a safe, productive, substance-abuse-free environment.

( ) 2) Employee Notification:

In order to protect the individual rights of each employee and to begin the employee education process necessary for a well-defined, well-managed workplace drug and alcohol abuse prevention program, each existing employee and each new employee hired after program implementation must be given a clear, concise, readable notice of the program, the program's requirements, the policy statement, and the employer's expectations under the program. Notification should be, and should remain posted in employee common areas. In addition, each existing employee and each new employee must be given, by mail or by in-person delivery, a copy of the notice. Delivery may be accomplished by inclusion of the notice within the employee's paycheck package or any similarly important-to-the-employee correspondence or benefits delivery.

( ) 3) Testing Procedure:

The testing procedure must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer and must provide for a second test to be administered within thirty minutes of the administration of the first test. Positive test results must be provided in writing to the employee within twenty-four hours of the time the employer receives the test results. Each employer must keep records of each test for up to one year.

( ) 4) Test Results Confidentially Protocols:

Test results, information, interviews, reports, statements, and memorandums received by the employer must be considered confidential and may not be used, received, or discovered in civil, criminal, or administrative proceedings. The burden to protect against unauthorized release is placed not only upon the employer and any laboratory, medical review officer, or rehabilitation program or their agents, but also upon the underwriting insurer. Employers, laboratories, medical review officers, insurers, drug or alcohol rehabilitation programs, and employer drug prevention programs, and their agents who receive or have access to information concerning test results shall keep all information confidential. Release of such information under any other circumstance shall be solely pursuant to a written consent form signed voluntarily by the employee tested or his designee unless the release is completed through disclosure by an agency of the State in a civil or administrative proceeding, order of a court of competent jurisdiction, or determination of a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain at a minimum:

(1) the name of the person who is authorized to obtain the information;
(2) the purpose of the disclosure;
(3) the precise information to be disclosed;
(4) the duration of the consent; and
(5) the signature of a person authorizing release of the information.

Information on test results shall not be released for or used or admissible in any criminal proceeding against the employee.

I certify that the above information is accurate and that I may be subject to an additional premium charge if it is determined that there is any misrepresentation of the established drug and alcohol free workplace program criteria. This is a true and factual depiction of my current program.

Employer Name	Date	Officer/Owner Signature*

Application must be signed by an officer or owner

Title

Notary Public's Signature	Date	Exp. of Commission

Form WC 66 02 85 A Printed in U.S.A.
Process Date: 10/10/13

Policy Expiration Date: 10/01/14

WORKERS' COMPENSATION COST CONTAINMENT CERTIFICATION DISCLOSURE STATEMENT

Cost Containment Certification is available from the Colorado Workers' Compensation Cost Containment Board. If you obtain certification, your policy will be subject to a premium credit which will be shown separately on your policy.

PLEASE CHECK ONE (1) OF THE FOLLOWING BOXES BASED UPON YOUR BUSINESS ENTITY QUALIFICATION:

☐ I am aware if my business **does qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business has implemented a certified workers' compensation risk management program, my policy is subject to a 5% premium credit if the loss experience has improved since the last renewal date of workers' compensation insurance. This 5% premium credit is in addition to any schedule rating for which I may qualify.

or,

☐ I am aware if my business **does not qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business entity has implemented a certified workers' compensation risk management program, my policy is subject to the following premium credit:

Premium Dividend	Dividend Criteria
10%	If my business has been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If my business had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If my business had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
4%	If my business had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
2%	If my business had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If my business had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

PLEASE SIGN AND RETURN

Insured Signature

Policy Number 37 WB BN3284

Issuing Office **THE HARTFORD**
Issuing Office Address **8711 UNIVERSITY EAST DRIVE**
CHARLOTTE NC **28213**

IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized $2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject this deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone No.: ( ) _____
C. Address: _____

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

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.
THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature	Date	Expiration of Commission

WEST VIRGINIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

West Virginia Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	**$100**	1.7%	1.2%	1.0%	0.8%	0.6%	0.4%	0.3%
( )	**$200**	2.9%	2.2%	1.8%	1.5%	1.1%	0.8%	0.6%
( )	**$300**	3.7%	2.8%	2.3%	1.9%	1.6%	1.1%	0.8%
( )	**$400**	4.3%	3.4%	2.8%	2.3%	1.9%	1.3%	1.0%
( )	**$500**	4.9%	3.8%	3.2%	2.7%	2.2%	1.5%	1.1%
( )	**$1,000**	7.0%	5.5%	4.8%	3.9%	3.3%	2.3%	1.8%
( )	**$1,500**	8.6%	6.9%	6.0%	5.0%	4.2%	3.0%	2.3%
( )	**$2,000**	10.0%	8.1%	7.0%	6.0%	5.0%	3.7%	2.9%
( )	**$2,500**	11.2%	9.1%	7.9%	6.8%	5.7%	4.3%	3.4%
( )	**$5,000**	16.3%	13.4%	11.9%	10.4%	8.9%	6.9%	5.4%
( )	**$7,500**	20.0%	16.8%	15.1%	13.3%	11.5%	9.1%	7.2%
( )	**$10,000**	23.1%	19.7%	17.8%	15.8%	13.7%	11.0%	8.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to:
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

Form WC 66 03 88 D Printed in U.S.A.
Process Date: 10/10/13
Policy Expiration Date: 10/01/14

Network Referral Unit

What is a Workers' Compensation medical network?

A medical network is simply an organization that has ready access to physicians, hospitals and other medical care providers who have experience treating Workers' Compensation related injuries. It also helps you manage the cost associated with those injuries. The Hartford has contracted with existing medical networks across the United States to provide this service to our Workers' Compensation customers.

What is the Network Referral Unit?

The Hartford's Network Referral Unit (NRU) helps you identify the appropriate medical care providers in your area. The NRU will provide you with immediate information by telephone or by mailing or faxing a list of providers. Please be sure to post the list where all employees will have access to it.

When should you contact the Network Referral Unit?

Now. Even before one of your employees is injured, we urge you to get a listing of approved medical providers in your area. In case of an injury, you will know who to call to get your employee immediate and appropriate medical attention.

How do you use the Network Referral Unit Services?

Call 1-800-327-3636. You will need to provide the network referral analyst with a complete address of your work location so he/she can identify a medical provider. Employees also have the option to seek a referral where they live.

If you have any questions regarding a specific claim or rules that govern use of network providers, contact your local Hartford Claims Office.

The Hartford's Network Referral Unit

Call 1-800-327-3636

At the prompt PRESS 4

Monday through Friday
7 am to 7 pm CST

You can leave a voicemail message after 7 pm and your call will be returned the next business day.

Report all work-related injuries to your supervisor immediately.

IN CASE OF INJURY OR ILLNESS ON THE JOB, CALL...

MEDICAL CARE COORDINATORS

_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
_____ _____
_____ _____
_____ _____

HOSPITALS

_____ _____
_____ _____
_____ _____
_____ _____

TO UPDATE PROVIDER INFORMATION CALL
THE HARTFORD'S NETWORK REFERRAL UNIT
AT 1-800-327-3636, PROMPTLY

THE HARTFORD

Date Posted

WC 55 00 26 A

INSTRUCTIONS

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

As of January 1, 1990, California employers are required by law to furnish a claim form to an injured worker within one working day of knowledge of a work-related injury or illness (other than First Aid). While it is mandatory for the employer to furnish the claim form to the employee, **it is not mandatory for the employee to complete it.**

The employer should complete sections 9-17, with the exception of section 13 (which reads, "Date employer received claim form"). This is to be completed **after** the claimant has completed his or her portion of the claim form and returned it to you, at which time section 13 should be **immediately** filled out or date stamped.

Penalties can be invoked if employers fail to provide an injured employee an EMPLOYEE'S CLAIM FOR COMPENSATION BENEFITS form or if employers fail to report the claim to the workers' compensation insurance carrier.

DO NOT DELAY REPORTING A CLAIM TO THE HARTFORD:

Whether or not the employee completes the EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS, please contact The Hartford's **LossConnect (1-800-327-3636)** to report every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond First Aid.

NOTIFICATION OF ACCIDENT PREVENTION SERVICES

THE HARTFORD is required by law to provide its policyholders with certain accident prevention services as required by K.S.A. 44-5, 104 at no additional cost. If you would like more information call:

The Hartford
Loss Control Department
7300 West 110th Street
Overland Park, Kansas 66210
(800) 255-6440, Extension 38574
(913) 693-8567

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

The Hartford is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact The Hartford at 1-860-547-7761 and email contactlosscontrol@thehartford.com for accident prevention services or 1-877-889-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

NOTIFICATION OF ACCIDENT PREVENTION SERVICES

SEE ATTACHED ENDORSEMENT **is required to provide policyholders**
(name of company)

with workplace safety services. If you would like more information, call:

The Hartford
Loss Control Department
300 Internet Boulevard
Frisco, TX 75034
1-469-287-1026

84 (Policy Provisions: WC 00 00 00 B)
32
BN **INFORMATION PAGE**
WB **WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY**

INSURER: SEE ATTACHED ENDORSEMENT

THE HARTFORD

NCCI Company Number: 14974
Company Code: 9

TWIN CITY FIRE INSURANCE COMPANY IS REQUIRED BY LAW TO PROVIDE ITS POLICYHOLDERS WITH CERTAIN ACCIDENT PREVENTION SERVICES AT NO ADDITIONAL COST AS REQUIRED BY ARK. CODE ANN. '11-9-409(D) AND RULE 32. IF YOU WOULD LIKE MORE INFORMATION, CALL THE HARTFORD, LOSS CONTROL DEPARTMENT, ONE HARTFORD PLAZA, CALD-2-45, HARTFORD, CT 06155, 1-860-547-7761. IF YOU HAVE ANY QUESTIONS ABOUT THIS REQUIREMENT, CALL THE HEALTH AND SAFETY DIVISION, ARKANSAS WORKERS COMPENSATION COMMISSION AT 1-800-622-4472.

		Suffix LARS	Suffix RENEWAL
POLICY NUMBER:	37 WB BN3284		01
Previous Policy Number:	37 WB BN3284		

HOUSING CODE: K3

1. **Named Insured and Mailing Address:** WALSWORTH PUBLISHING COMPANY, INC.
(No., Street, Town, State, Zip Code)

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

FEIN Number: 430718484

State Identification Number(s):

MI. RISK ID NO: 00924415A

The Named Insured is: CORPORATION
Business of Named Insured: YEARBOOK/HISTORY BOOKS PUBLISH
Other workplaces not shown above: SEE ATTACHED SCHEDULES

2. **Policy Period:** **From** 10/01/13 **To** 10/01/14
12:01 a.m., Standard time at the insured's mailing address.

Producer's Name: LOCKTON COMPANIES LLC

444 W 47TH STREET SUITE 900
KANSAS CITY, MO 64112

Producer's Code: 330027
Issuing Office: THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

Total Estimated Annual Premium: $1,297,105
Deposit Premium: N/A
Policy Minimum Premium: $850 NE (INCLUDES INCREASED LIMIT MIN. PREM.)

Audit Period: ANNUAL **Installment Term:** 10

The policy is not binding unless countersigned by our authorized representative.

Countersigned by _____
Authorized Representative Date

3. A. Workers Compensation Insurance: Part one of the policy applies to the Workers Compensation Law of the states listed here: AL (SP0),AZ (SP0),AR (SP0),CA (SP0),CO (9A), CT (SP0),FL (SP0). SEE ENDT

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	$500,000	**each accident**
Bodily injury by Disease	$500,000	**policy limit**
Bodily injury by Disease	$500,000	**each employee**

C. Other States Insurance: Part Three of the policy applies to the states, if any , listed here:

ALL STATES EXCEPT ND, OH, WA, AND
STATES DESIGNATED IN ITEM 3.A. OF THE INFORMATION PAGE.

D. This policy includes these endorsements and schedule:
WC 99 00 05 WC 00 04 06A WC 00 04 06 WC 00 03 11A WC 00 03 11
SEE ENDT

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
(SEE ATTACHED SCHEDULES)			
INCREASED LIMITS PART TWO (9807)			5,466
CA TERRITORIAL DIFFERENTIAL PREMIUM 9684 (1.100)			1,504
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			681,373
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,076,749
SCHEDULE MODIFICATION			240,955
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,334,520
LOSS CONSTANT			20
EXPENSE CONSTANT (0900)			280
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,334,540
PREMIUM DISCOUNT			-81,838
TOTAL ESTIMATED STATE SURCHARGE			30,153
TERRORISM (9740)			10,993
TERRORISM (9740) PER CAPITA			0
CATASTROPHE (9741)			2,977
CATASTROPHE (9741) PER CAPITA			0
TOTAL ESTIMATED ANNUAL PREMIUM			1,297,105

Total Estimated Annual Premium: $1,297,105
Deposit Premium: N/A
Policy Minimum Premium: $850 NE (INCLUDES INCREASED LIMIT MIN. PREM.)

Interstate/Intrastate Identification Number: 910456369 /

Labor Contractors Policy Number:

NAICS: 323110
SIC: 2752

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-01-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF AL

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 2

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	90,000	1.05	945
TOTAL CLASS PREMIUM			945
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			10
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			955
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,595
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,595
PREMIUM DISCOUNT 6.1 PERCENT			-97
TERRORISM (9740)	90,000	.020	18
CATASTROPHE (9741)	90,000	.020	18
TOTAL ESTIMATED ANNUAL PREMIUM			1,534

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY & CASUALTY INS CO. OF HARTFORD

Company Code: P

Policy Number: 37 WB BN3284 **Schedule Number:** 01-02-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF AZ

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 2

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, OR COLLECTORS - OUTSIDE	160,000	.49	784
TOTAL CLASS PREMIUM			784
INCREASED LIMITS PART TWO (9807) .80 PERCENT			6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			790
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,319
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,319
PREMIUM DISCOUNT 6.3 PERCENT			-83
TERRORISM (9740)	160,000	.010	16
CATASTROPHE (9741)	160,000	.010	16
TOTAL ESTIMATED ANNUAL PREMIUM			1,268

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-03-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF AR

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, OR COLLECTORS - OUTSIDE	90,000	.31	279
TOTAL CLASS PREMIUM			279
INCREASED LIMITS PART TWO (9807) .80 PERCENT			2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			281
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			469
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			469
PREMIUM DISCOUNT 6.1 PERCENT			-29
TERRORISM (9740)	90,000	.020	18
CATASTROPHE (9741)	90,000	.020	18
TOTAL ESTIMATED ANNUAL PREMIUM			476

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-04-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF CA 92274

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 19

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS - OUTSIDE	1,350,000	1.11	14,985
8810 CLERICAL OFFICE EMPLOYEES-N O C	6,000	.84	50
TOTAL CLASS PREMIUM			15,035
CA TERRITORIAL DIFFERENTIAL PREMIUM 9684 1.100			1,504
CA - SCHEDULE MODIFICATION (1.500) (9889)			8,270
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			24,809
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			24,809
PREMIUM DISCOUNT 6.1 PERCENT			-1,513
CA SURCHARGE 2.000 PERCENT			474
USER FUNDING ASSESSMENT 1.3704 PERCENT			325
FRAUD ASSESSMENT 0.3881 PERCENT			92
CA UNINSD EMPL BENEFIT TRUST FUND 0.3410 PERCENT			81
CA SUBSEQ INJ BENEFITS TRUST FUND 0.1707 PERCENT			40
CA OCCUP SAFETY AND HEALTH FUND 0.2859 PERCENT			68
CA LABOR ENFORCE AND COMPL FUND 0.2747 PERCENT			65
TERRORISM (9740)	1,356,000	.030	407
TOTAL ESTIMATED ANNUAL PREMIUM			24,848
DEPOSIT PREMIUM - CA			6,218

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-05-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF CO

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	45,000	.49	221
TOTAL CLASS PREMIUM			221
INCREASED LIMITS PART TWO (9807) .80 PERCENT			2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			223
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			372
CO - SCHEDULE MODIFICATION (1.250) (9889)			93
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			465
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			465
PREMIUM DISCOUNT 6.1 PERCENT			-28
TERRORISM (9740)	45,000	.010	5
CATASTROPHE (9741)	45,000	.010	5
TOTAL ESTIMATED ANNUAL PREMIUM			447

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-06-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF CT

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	135,000	.62	837
TOTAL CLASS PREMIUM			837
INCREASED LIMITS PART TWO (9807) .80 PERCENT			7
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			844
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,409
CT - SCHEDULE MODIFICATION (1.250) (9889)			352
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			1,761
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,761
PREMIUM DISCOUNT 6.1 PERCENT			-107
CONNECTICUT SECOND INJURY FUND 2.75 PERCENT			47
CONNECTICUT ASSESSMENT FUND 1.20 PERCENT			21
TERRORISM (9740)	135,000	.020	27
CATASTROPHE (9741)	135,000	.020	27
TOTAL ESTIMATED ANNUAL PREMIUM			1,776

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-09-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
8231 BAY COLONY DR UNIT 1701
NAPLES FL 34108

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 6

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	1,000,000	.53	5,300
8810 CLERICAL OFFICE EMPLOYEES NOC	55,000	.27	149
TOTAL CLASS PREMIUM			5,449
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			60
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			5,509
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			9,200
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			9,200
PREMIUM DISCOUNT 6.3 PERCENT			-580
TERRORISM (9740)	1,055,000	.020	211
TOTAL ESTIMATED ANNUAL PREMIUM			8,831

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD INSURANCE COMPANY OF THE MIDWEST

Company Code: G

Policy Number: 37 WB BN3284 **Schedule Number:** 01-10-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF GA

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	375,000	.67	2,513
TOTAL CLASS PREMIUM			2,513
INCREASED LIMITS PART TWO (9807) .80 PERCENT			20
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			2,533
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			4,230
GA - SCHEDULE MODIFICATION (1.200) (9889)			846
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			5,076
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			5,076
PREMIUM DISCOUNT 6.1 PERCENT			-310
TERRORISM (9740)	375,000	.020	75
CATASTROPHE (9741)	375,000	.020	75
TOTAL ESTIMATED ANNUAL PREMIUM			4,916

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-11-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF ID

NAICS: 323110
FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	135,000	.54	729
TOTAL CLASS PREMIUM			729
INCREASED LIMITS PART TWO (9807) .80 PERCENT			6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			735
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,227
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,227
PREMIUM DISCOUNT 6.3 PERCENT			-77
TERRORISM (9740)	135,000	.020	27
CATASTROPHE (9741)	135,000	.010	14
TOTAL ESTIMATED ANNUAL PREMIUM			1,191

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-12-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF IL

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 12

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	850,000	.61	5,185
8810 CLERICAL OFFICE EMPLOYEES NOC	120,000	.28	336
TOTAL CLASS PREMIUM			5,521
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			61
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			5,582
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			9,322
IL - SCHEDULE MODIFICATION (1.600) (9889)			5,593
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			14,915
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			14,915
PREMIUM DISCOUNT 6.1 PERCENT			-910
EXPENSE CONSTANT (0900)			280
IL INDUSTRIAL COMMISSION SURCHARGE 1.01 PERCENT			152
TERRORISM (9740)	970,000	.060	582
CATASTROPHE (9741)	970,000	.020	194
TOTAL ESTIMATED ANNUAL PREMIUM			15,213

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-13-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF IN

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
4299 PRINTING	IF ANY	1.68	
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	90,000	.36	324
8810 CLERICAL OFFICE EMPLOYEES NOC	IF ANY	.20	
TOTAL CLASS PREMIUM			324
INCREASED LIMITS PART TWO (9807) .80 PERCENT			3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			327
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			546
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			546
PREMIUM DISCOUNT 6.3 PERCENT			-34
INDIANA SECOND INJURY FUND (0.78%) (0935)			4
TERRORISM (9740)	90,000	.010	9
CATASTROPHE (9741)	90,000	.010	9
TOTAL ESTIMATED ANNUAL PREMIUM			534

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-14-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF IA

NAICS: 323110
FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	97,000	.64	621
TOTAL CLASS PREMIUM			621
INCREASED LIMITS PART TWO (9807) .80 PERCENT			5
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			626
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,045
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,045
PREMIUM DISCOUNT 6.3 PERCENT			-66
TERRORISM (9740)	97,000	.020	19
CATASTROPHE (9741)	97,000	.010	10
TOTAL ESTIMATED ANNUAL PREMIUM			1,008

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 37 WB BN3284 **Schedule Number:** 01-15-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
15721 COLLEGE BLVD
LENEXA KS 66219

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	200,000	.48	960
8810 CLERICAL OFFICE EMPLOYEES NOC	175,000	.26	455
TOTAL CLASS PREMIUM			1,415
INCREASED LIMITS PART TWO (9807) .80 PERCENT			11
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,426
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			2,381
KS - SCHEDULE MODIFICATION (1.250) (9889)			595
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			2,976
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			2,976
PREMIUM DISCOUNT 6.1 PERCENT			-182
TERRORISM (9740)	375,000	.020	75
CATASTROPHE (9741)	375,000	.020	75
TOTAL ESTIMATED ANNUAL PREMIUM			2,944

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-16-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO PHYSICAL ADDRESS
NO PHYSICAL ADDRESS KY 40003

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE AND ALL OTHER CLASSIFICATIONS APPLICABLE TO THE INSURED'S BUSINESS EXCEPT FARM LABOR AND DOMESTIC SERVANTS	IF ANY	.68	
INTERSTATE EXPERIENCE MODIFICATION 910456369	(PRELIMINARY)		1.670
TERRORISM (9740)	0	.020	0
CATASTROPHE (9741)	0	.020	0

Countersigned by _____
Authorized Representative

Form WC 99 00 05 **(1)** Printed in U.S.A.
Process Date: 10/10/13 **Policy Expiration Date:** 10/01/14

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-19-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF MD

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	120,000	.42	504
TOTAL CLASS PREMIUM			504
INCREASED LIMITS PART TWO (9807) .80 PERCENT			4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			508
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			848
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			848
PREMIUM DISCOUNT 6.1 PERCENT			-52
TERRORISM (9740)	120,000	.050	60
CATASTROPHE (9741)	120,000	.020	24
TOTAL ESTIMATED ANNUAL PREMIUM			880

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-20-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF MA

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS OR MESSENGERS - OUTSIDE	125,000	.15	188
TOTAL CLASS PREMIUM			188
INCREASED LIMITS PART TWO (9807) 1.00 PERCENT			2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			190
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			317
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			317
LOSS CONSTANT			20
PREMIUM DISCOUNT 6.3 PERCENT			-20
MASSACHUSETTS DIA ASSESSMENT 3.400 PERCENT			11
TERRORISM (9740)	125,000	.030	38
TOTAL ESTIMATED ANNUAL PREMIUM			366

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 37 WB BN3284 **Schedule Number:** 01-21-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
2180 MAIDEN LANE
ST. JOSEPH MI 49085

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 152

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
4299 PRINTING	5,500,000	2.70	148,500
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS-OUTSIDE	1,150,000	.42	4,830
8810 CLERICAL OFFICE EMPLOYEES	2,000,000	.20	4,000
TOTAL CLASS PREMIUM			157,330
INCREASED LIMITS PART TWO (9807) .80 PERCENT			1,259
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			158,589
MI - INTRA EXPERIENCE MODIFICATION			1.310
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			207,752
MI - SCHEDULE MODIFICATION (1.090) (9889)			18,698
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			226,450
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			226,450
PREMIUM DISCOUNT 6.1 PERCENT			-13,813
TERRORISM (9740)	8,650,000	.020	1,730
CATASTROPHE (9741)	8,650,000	.020	1,730
TOTAL ESTIMATED ANNUAL PREMIUM			216,097

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-23-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF MS

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	125,000	.89	1,113
TOTAL CLASS PREMIUM			1,113
INCREASED LIMITS PART TWO (9807) .80 PERCENT			9
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,122
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,874
MS - SCHEDULE MODIFICATION (1.250) (9889)			469
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			2,343
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			2,343
PREMIUM DISCOUNT 6.1 PERCENT			-143
TERRORISM (9740)	125,000	.020	25
CATASTROPHE (9741)	125,000	.020	25
TOTAL ESTIMATED ANNUAL PREMIUM			2,250

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY & CASUALTY INS CO. OF HARTFORD

Company Code: P

Policy Number: 37 WB BN3284 **Schedule Number:** 01-24-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
306 N KANSAS AVE
MARCELINE MO 64658

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 916

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
4299 PRINTING	10,000,000	3.90	390,000
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	1,200,000	.71	8,520
8810 CLERICAL OFFICE EMPLOYEES NOC	19,000,000	.35	66,500
TOTAL CLASS PREMIUM			465,020
INCREASED LIMITS PART TWO (9807) .80 PERCENT			3,720
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			468,740
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			782,796
MO - SCHEDULE MODIFICATION (1.250) (9889)			195,699
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			978,495
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			978,495
PREMIUM DISCOUNT 6.1 PERCENT			-59,688
MISSOURI SURCHARGE 3.00 PERCENT			27,745
TERRORISM (9740)	30,200,000	.020	6,040
TOTAL ESTIMATED ANNUAL PREMIUM			952,592

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-25-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO PHYSICAL ADDRESS
NO PHYSICAL ADDRESS MT 59001

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	65,000	.81	527
TOTAL CLASS PREMIUM			527
INCREASED LIMITS PART TWO (9807) .80 PERCENT			4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			531
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			887
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			887
PREMIUM DISCOUNT 6.1 PERCENT			-54
MT REGULATORY ASSESSMENT SURCH (1.9328%)			16
MT SUBSEQUENT INJURY FUND SURCH (0.3427%)			3
TERRORISM (9740)	65,000	.010	7
CATASTROPHE (9741)	65,000	.010	7
TOTAL ESTIMATED ANNUAL PREMIUM			866

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 37 WB BN3284 **Schedule Number:** 01-26-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
1508 CHANDLER
OMAHA NE 68147

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
4299 PRINTING	IF ANY	3.49	
7380 DRIVERS, CHAUFFEURS, MESSENGERS, AND THEIR HELPERS NOC - COMMERCIAL	IF ANY	7.18	
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	620,000	.64	3,968
8810 CLERICAL OFFICE EMPLOYEES NOC	IF ANY	.32	

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 37 WB BN3284 **Schedule Number:** 01-26-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
1508 CHANDLER
OMAHA NE 68147

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
TOTAL CLASS PREMIUM			3,968
INCREASED LIMITS PART TWO (9807) .80 PERCENT			32
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			4,000
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			6,680
NE - FLEXIBLE RATING ADJUSTMENT (1.400) (9659)			2,672
PREMIUM ADJUSTED BY FLEXIBLE RATING ADJUSTMENT			9,352
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			9,352
PREMIUM DISCOUNT 6.1 PERCENT			-570
TERRORISM (9740)	620,000	.020	124
CATASTROPHE (9741)	620,000	.020	124
TOTAL ESTIMATED ANNUAL PREMIUM			9,030

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-27-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NV (660) 376-3543
NAICS: 323110
FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	40,000	.97	388
TOTAL CLASS PREMIUM			388
INCREASED LIMITS PART TWO (9807) .80 PERCENT			3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			391
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			653
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			653
PREMIUM DISCOUNT 6.3 PERCENT			-41
TERRORISM (9740)	40,000	.010	4
CATASTROPHE (9741)	40,000	.010	4
TOTAL ESTIMATED ANNUAL PREMIUM			620

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-28-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NH

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	130,000	.88	1,144
TOTAL CLASS PREMIUM			1,144
INCREASED LIMITS PART TWO (9807) .80 PERCENT			9
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,153
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,926
NH - SCHEDULE MODIFICATION (1.250) (9889)			482
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			2,408
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			2,408
PREMIUM DISCOUNT 6.1 PERCENT			-147
TERRORISM (9740)	130,000	.020	26
CATASTROPHE (9741)	130,000	.020	26
TOTAL ESTIMATED ANNUAL PREMIUM			2,313

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-29-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NJ

NAICS: 323110

FEIN: 430718484 NJ TIN: 430718484000 SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSON, COLLECTORS, OR MESSENGERS - OUTSIDE	325,000	.64	2,080
TOTAL CLASS PREMIUM			2,080
INCREASED LIMITS PART TWO (6199) 1.10 PERCENT			23
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			2,103
NJ - INTRA EXPERIENCE MODIFICATION			.976
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			2,053
NJ - SCHEDULE MODIFICATION (1.200) (9889)			411
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			2,464
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			2,464
NJ ESTIMATED 2ND INJURY FUND SURCHARGE 6.760 PERCENT			139
TERRORISM (9740)	325,000	.030	98
CATASTROPHE (9741)	325,000	.010	33
TOTAL ESTIMATED ANNUAL PREMIUM			2,734

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-30-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NM

NAICS: 323110

FEIN: 430718484 UIN: SIC: NO. OF EMPL: 0

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	IF ANY	.65	
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
TERRORISM (9740)	0	.010	0

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY & CASUALTY INS CO. OF HARTFORD

Company Code: P

Policy Number: 37 WB BN3284 **Schedule Number:** 01-31-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NY

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 3

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS OR MESSENGERS - OUTSIDE	310,000	.64	1,984
TOTAL CLASS PREMIUM			1,984
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,984
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			3,313
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			3,313
PREMIUM DISCOUNT 13.6 PERCENT			-451
NEW YORK STATE ASSESSMENT (0932) 18.80 PERCENT			664
TERRORISM (9740)	310,000	.060	186
TERRORISM (9740) PER CAPITA 2.9 PERCENT			0
CATASTROPHE (9741)	310,000	.010	31
CATASTROPHE (9741) PER CAPITA 0.7 PERCENT			0
TOTAL ESTIMATED ANNUAL PREMIUM			3,743

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-32-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF NC

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 7

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	625,000	.59	3,688
8810 CLERICAL OFFICE EMPLOYEES NOC	22,000	.27	59
TOTAL CLASS PREMIUM			3,747
INCREASED LIMITS PART TWO (9807) .80 PERCENT			30
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			3,777
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			6,308
NC - SCHEDULE MODIFICATION (1.250) (9889)			1,577
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			7,885
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			7,885
PREMIUM DISCOUNT 6.1 PERCENT			-481
TERRORISM (9740)	647,000	.020	129
CATASTROPHE (9741)	647,000	.020	129
TOTAL ESTIMATED ANNUAL PREMIUM			7,662

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-34-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF OH

NAICS: 323110
FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 5

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
9139 STOP GAP	420,000	.02	250
TOTAL CLASS PREMIUM			250
INCREASED LIMITS PART TWO (9807) .80 PERCENT			2
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			252
TOTAL ESTIMATED ANNUAL PREMIUM			252

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-35-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF OK

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	95,000	.86	817
TOTAL CLASS PREMIUM			817
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			9
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			826
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,379
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,379
PREMIUM DISCOUNT 6.1 PERCENT			-84
TERRORISM (9740)	95,000	.020	19
CATASTROPHE (9741)	95,000	.020	19
TOTAL ESTIMATED ANNUAL PREMIUM			1,333

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-36-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF OR

NAICS: 323110

FEIN: 430718484 UIN: SIC: NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 ADVERTISING SOLICITORS	90,000	.38	342
TOTAL CLASS PREMIUM			342
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			342
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			571
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			571
PREMIUM DISCOUNT 6.1 PERCENT			-35
OR WC ADMINISTRATIVE FUND 6.20 PERCENT			35
TERRORISM (9740)	90,000	.020	18
CATASTROPHE (9741)	90,000	.020	18
TOTAL ESTIMATED ANNUAL PREMIUM			607

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 37 WB BN3284 **Schedule Number:** 01-37-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF PA

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 5

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
951 SALESPERSONS - OUTSIDE	400,000	.89	3,560
TOTAL CLASS PREMIUM			3,560
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			39
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			3,599
PA - MERIT RATING CREDIT (9885)			.950
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			3,419
PA - SCHEDULE MODIFICATION (1.250) (9889)			855
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			4,274
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			4,274
PREMIUM DISCOUNT 6.1 PERCENT			-261
PA EMPLOYER ASSESSMENT 2.62 PERCENT			112
TERRORISM (9740)	400,000	.050	200
CATASTROPHE (9741)	400,000	.020	80
TOTAL ESTIMATED ANNUAL PREMIUM			4,405

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-39-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF SC

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	125,000	.83	1,038
TOTAL CLASS PREMIUM			1,038
INCREASED LIMITS PART TWO (9807) .80 PERCENT			8
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,046
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,747
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,747
PREMIUM DISCOUNT 6.1 PERCENT			-107
TERRORISM (9740)	125,000	.020	25
CATASTROPHE (9741)	125,000	.020	25
TOTAL ESTIMATED ANNUAL PREMIUM			1,690

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-40-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF SD

NAICS: 323110
FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 0

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	IF ANY	.73	
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
TERRORISM (9740)	0	.020	0
CATASTROPHE (9741)	0	.020	0

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: SENTINEL INSURANCE COMPANY, LIMITED

Company Code: A

Policy Number: 37 WB BN3284 **Schedule Number:** 01-41-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF TN

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 8

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	645,000	.65	4,193
TOTAL CLASS PREMIUM			4,193
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT			46
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			4,239
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			7,079
TN - SCHEDULE MODIFICATION (1.250) (9889)			1,770
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			8,849
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			8,849
PREMIUM DISCOUNT 6.1 PERCENT			-540
TERRORISM (9740)	645,000	.020	129
CATASTROPHE (9741)	645,000	.030	194
TOTAL ESTIMATED ANNUAL PREMIUM			8,632

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: SENTINEL INSURANCE COMPANY, LIMITED

Company Code: A

Policy Number: 37 WB BN3284 **Schedule Number:** 01-42-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO PHYSICAL ADDRESS
NO PHYSICAL ADDRESS TX 73301

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 9

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	725,000	.37	2,683
8810 CLERICAL OFFICE EMPLOYEES NOC	125,000	.24	300
TOTAL CLASS PREMIUM			2,983
INCREASED LIMITS PART TWO (9807) 1.00 PERCENT			30
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			3,013
INTERSTATE EXPERIENCE MODIFICATION 910456369			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			5,032
TX - SCHEDULE MODIFICATION (1.400) (9889)			2,013
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			7,045
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			7,045
PREMIUM DISCOUNT 10.6 PERCENT			-747
TERRORISM (9740)	850,000	.024	204
TOTAL ESTIMATED ANNUAL PREMIUM			6,502

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-45-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
184 BUSINESS PARK DR, STE 206 & 207
VIRGINIA BEACH VA 23462

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 21

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	600,000	.30	1,800
8810 CLERICAL OFFICE EMPLOYEES NOC	320,000	.13	416
TOTAL CLASS PREMIUM			2,216
INCREASED LIMITS PART TWO (9807) .80 PERCENT			18
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			2,234
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			3,731
VA - SCHEDULE MODIFICATION (1.150) (9889)			560
PREMIUM ADJUSTED BY SCHEDULE MODIFICATION			4,291
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			4,291
PREMIUM DISCOUNT 6.1 PERCENT			-262
TERRORISM (9740)	920,000	.040	368
TOTAL ESTIMATED ANNUAL PREMIUM			4,397

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-46-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF WA

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 2

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
9139 STOP GAP - FLAT CHARGE	395,000	25.00	25
TOTAL CLASS PREMIUM			25
TOTAL ESTIMATED ANNUAL PREMIUM			25

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 37 WB BN3284 **Schedule Number:** 01-47-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF WV

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 01

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	50,000	.52	260
TOTAL CLASS PREMIUM (STATE)			260
INCREASED LIMITS PART TWO (9807) 1.10 PERCENT (STATE)			3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION (FEDERAL)			3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION (STATE)			260
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXP MODIFICATION (FEDERAL)			5
PREMIUM ADJUSTED BY APPLICATION OF EXP MODIFICATION (STATE)			434
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM (FEDERAL)			5
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM (STATE)			434
PREMIUM DISCOUNT (STATE) 6.1 PERCENT			-26
FOREIGN TERRORISM (9740)	50,000	.010	5
DTEC (9741)	50,000	.010	5
REGULATORY SURCHARGE (5.00)			21
DEBT REDUCTION SURCHARGE (9.00)			38
FIRE AND CASUALTY SURCHARGE (.55)			0
TOTAL ESTIMATED ANNUAL PREMIUM			482

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-48-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF WI

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 2

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	275,000	.67	1,843
TOTAL CLASS PREMIUM			1,843
INCREASED LIMITS PART TWO (9807) .80 PERCENT			15
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,858
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			3,103
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			3,103
PREMIUM DISCOUNT 6.3 PERCENT			-195
TERRORISM (9740)	275,000	.020	55
CATASTROPHE (9741)	275,000	.010	28
TOTAL ESTIMATED ANNUAL PREMIUM			2,991

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-49-01

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF WY

NAICS: 323110

FEIN: 430718484 UIN: SIC: 2752 NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	135,000	.76	1,026
TOTAL CLASS PREMIUM			1,026
INCREASED LIMITS PART TWO (9807) .80 PERCENT			8
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION			1,034
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION			1,727
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			1,727
PREMIUM DISCOUNT 6.1 PERCENT			-105
TERRORISM (9740)	135,000	.010	14
CATASTROPHE (9741)	135,000	.010	14
TOTAL ESTIMATED ANNUAL PREMIUM			1,650

Countersigned by _____
Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 37 WB BN3284 **Schedule Number:** 01-22-01
Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Location Address of operations covered by this schedule:
WALSWORTH PUBLISHING COMPANY, INC.
NO SPECIFIC LOCATION
IN STATE OF MN

NAICS: 323110
FEIN: 430718484 UIN: 000430718484 SIC: NO. OF EMPL: 0

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	IF ANY	.75	
INTERSTATE EXPERIENCE MODIFICATION 910456369 (PRELIMINARY)			1.670
MN SPECIAL COMPENSATION FUND 4.00 PERCENT			0
MN WC REINSURANCE ASSO DEFICIENCY ASSM .7700 PERCENT			0
TERRORISM (9740)	0	.020	0

Countersigned by _____
Authorized Representative

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

Form WC 66 01 56 B Printed in U.S.A.
Process Date: 10/10/13 **Policy Expiration Date:** 10/01/14

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. The Policy

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

B. Who Is Insured

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

C. Workers Compensation Law

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

D. State

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

E. Locations

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

PART ONE - WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

1. reasonable expenses incurred at our request, but not loss of earnings;

2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

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

F. Payments You Must Make

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

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

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

G. Recovery From Others

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

H. Statutory Provisions

These statements apply where they are required by law.

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

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

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

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last

exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

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

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

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

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a.), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945) any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

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

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

E. We Will Also Pay

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

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

F. Other Insurance

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

G. Limits of Liability

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

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident-each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

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

   Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

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

I. Actions Against Us

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

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

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE - OTHER STATES INSURANCE

A. How This Insurance Applies

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

Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

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

PART FOUR - YOUR DUTIES IF INJURY OCCURS

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

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis.

This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

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

D. Premium Payments

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

E. Final Premium

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

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

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

F. Records

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

G. Audit

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

PART SIX - CONDITIONS

A. Inspection

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation

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

E. Sole Representative

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

IMPORTANT NOTICE

MONTANA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Montana Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to medical and indemnity claims or medical only claims paid under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

MEDICAL AND INDEMNITY PER CLAIM

		A	B	C	D	E	F	G
( )	$ 1,000	4.3%	3.3%	2.8%	2.3%	2.0%	1.3%	0.9%
( )	$ 2,000	6.4%	5.1%	4.3%	3.6%	3.0%	2.1%	1.6%
( )	$ 2,500	7.2%	5.7%	4.9%	4.2%	3.5%	2.5%	1.8%
( )	$ 5,000	10.6%	8.5%	7.4%	6.4%	5.4%	4.0%	3.0%
( )	$ 10,000	15.4%	12.8%	11.2%	9.9%	8.5%	6.6%	4.9%

MEDICAL PER CLAIM

		A	B	C	D	E	F	G
( )	$ 500	2.8%	2.1%	1.8%	1.5%	1.2%	0.8%	0.6%
( )	$ 1,000	4.1%	3.2%	2.7%	2.2%	1.8%	1.3%	0.9%
( )	$ 1,500	5.1%	4.0%	3.3%	2.8%	2.3%	1.6%	1.2%
( )	$ 2,000	5.9%	4.7%	3.9%	3.3%	2.8%	2.0%	1.4%
( )	$ 2,500	6.6%	5.2%	4.4%	3.7%	3.1%	2.2%	1.6%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office:
Address:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

SCHEDULE

1. State — Estimated Eligible Premium

	First $10,000	Next $190,000	Next $1,550,000	Balance
AZ, FL, ID, IN, IA, MA, NV, WI	00.0%	5.1%	6.5%	7.5%

2. Average percentage discount: _____%

3. Other policies:

4. If there are no entries in Items 1, 2 and 3 of the Schedule, see the Premium Discount Endorsement attached to your policy number:

Countersigned by _____
Authorized Representative

Form WC 00 04 06 A

Process Date: 10/10/13 **Policy Expiration Date:** 10/01/14

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

SCHEDULE

State	First $5,000	Next $95,000	Next $400,000	Balance
NY	00.0%	10.9%	12.6%	14.4%
AL, AR, CA, CO, CT, GA, IL, KS, MD, MI, MS, MO, MT, NE, NH, NC, OK, OR, PA, SC, TN, VA, WV, WY	00.0%	3.5%	5.0%	7.0%
TX	00.0%	8.4%	10.5%	11.0%

Other Policy Numbers:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYERS' LIABILITY STOP GAP COVERAGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to work in the states shown in the Schedule.

I. Part One (Workers' Compensation Insurance) does not apply to work in a state shown in the Schedule.

II. Part Two (Employers' Liability Insurance) applies to work in the states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.

III. Part Two, Section C **Exclusions** is changed by adding these exclusions. This insurance does not cover:

5. bodily injury by accident or bodily injury by disease intentionally caused or aggravated by you, or bodily injury by accident or bodily injury by disease resulting from an act which is determined to have been committed by you if it was reasonable to believe that an injury is substantially certain to occur.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium payment under, or any other failure to comply with the provisions of the workers' compensation law or laws of a state shown in the Schedule.

SCHEDULE

State
OH, WA
ND WY - IF ANY

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement adds Voluntary Compensation Insurance to the policy.

A. How This Insurance Applies

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

1. The bodily injury must be sustained by an employee included in the group of employees described in the Schedule.
2. The bodily injury must arise out of and in the course of employment necessary or incidental to work in a state listed in the Schedule.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay an amount equal to the benefits that would be required of you if you and your employees described in the Schedule were subject to the Workers Compensation Law shown in the Schedule. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusions

This insurance does not cover:

1. any obligation imposed by a workers compensation or occupational disease law, or any similar law.
2. bodily injury intentionally caused or aggravated by you.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers Liability Insurance

Part Two (Employers Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment shown in the Schedule were shown in Item 3.A. of the Information Page.

SCHEDULE

Employees	State of Employment	Designated Workers Compensation Law
ALL OFFICERS AND EMPLOYEES NOT SUBJECT TO THE WORKERS COMPENSATION LAW	ANY STATE SHOWN IN ITEM 3.A. OF THE INFORMATION PAGE WI EXCLUDED	THE STATE WHERE THE INJURY TAKES PLACE

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement adds Voluntary Compensation Insurance to the policy.

A. How This Insurance Applies

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

1. The bodily injury must be sustained by an employee included in the group of employees described in Item 1 of the Schedule.
2. The bodily injury must occur in the course of employment necessary or incidental to work in a state listed in Item 1 of the Schedule.
3. The bodily injury must occur in the United States of America, its territories or possessions or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay an amount equal to the benefits that would be required of you if you and your employees described in Item 1 of the Schedule were subject to the workers compensation law shown in Item 1 of the Schedule. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusions

This insurance does not cover:

1. any obligation imposed by a workers compensation or occupational disease law, or any similar law.
2. bodily injury intentionally caused or aggravated by you.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recover From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers Liability Insurance

Part Two (Employers Liability Insurance) applies to bodily injury covered by this endorsement as though the State of employment shown in the Schedule were shown in Item 3.A. of the Information Page.

SCHEDULE

Employees	State of Employment	Designated Workers Compensation Law
ALL OFFICERS AND EMPLOYEES NOT SUBJECT TO THE WORKERS COMPENSATION LAW	ANY STATE SHOWN IN ITEM 3.A. OF THE INFORMATION PAGE WI EXCLUDED	THE STATE WHERE THE INJURY TAKES PLACE

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GEORGIA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

If you do not allow us to examine and audit all of your records that relate to this policy, we may utilize a payroll amount of three times the estimated payroll for purposes of determining final premium.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

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

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

2. Reserve or Settlements

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

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

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

   If you want to add a named insured or replace the named insured with another legal entity on any policy issued through the Massachusetts Assigned Risk Pool you must submit a new Assigned Risk Pool Application, including a Confidential Request for Information Form (ERM), to the Workers'

Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this Endorsement

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

Addresses

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

Company Address
THE HARTFORD

8711 UNIVERSITY EAST DRIVE

CHARLOTTE
NC 28213

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA EMPLOYERS LIABILITY
INTENTIONAL TORT EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

This insurance does not cover:

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL NAMED INSURED ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The policy is amended to include the following as additional named insureds:

DON & ED, INC.
THE DONNING COMPANY PUBLISHERS, INC.
LCAH, LLC

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or declarations of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersignature on the declarations page of said policy by a duly authorized agent of the company shall constitute valid countersignature of this endorsement

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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. PLEASE READ IT CAREFULLY.

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

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. PLEASE READ IT CAREFULLY.

ARIZONA ALCOHOL- AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

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

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

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

1. Insurers offering the premium credit program may apply a 5% premium credit to qualifying employers.
2. To receive the premium credit, you must:
   a. Provide a written statement to the insurer prior to or within 30 days after the beginning of the policy effective date each year, certifying that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14.
   b. At any time during the term of the policy, provide additional information to the insurer, as required, to confirm that a qualifying program has been established and is being maintained.
   c. Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, Article 14.
   d. Conduct alcohol and drug testing of prospective employees.
   e. Conduct alcohol and drug testing of an employee after the employee has been injured.
   f. Allow us to have access to the alcohol and drug testing results under d. and e. above.
3. The determination that you have established and maintain a qualifying program must be made during each policy term that you receive the premium credit.
4. Your certification and any other information relied upon by the insurer in granting the premium credit must be kept in the insurer's underwriting files and made available to the Department of Insurance upon request.
5. The premium credit may be applied after total premium has been paid for the policy period and may be revised at final audit to the employer's policy. The credit is applicable as a supplement to deviated rates and is applied in a multiplicative manner, after the application of the experience modification, and before the application of the premium discount and expense constant.
6. You must reimburse the premium credit if it is determined that you were not in compliance with the provisions of the program.
7. Minimum premium policies are eligible for this premium credit.
8. Residual market employers are eligible to apply for this premium credit.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

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.

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 the 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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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 payment of any portion of the amount of Insured Losses that exceeds $100,000,000,000. For aggregate Insured Losses up to $100,000,000,000, we will pay only a pro rata share of such Insured Losses as determined by the Secretary of the Treasury.

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses 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 exceeds $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is shown in Item 4 of the Information Page.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DUE DATE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.**

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS CANCELLATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Cancellation

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

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

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

4. Any of these provisions that conflict with the law that controls the cancellation of this insurance policy is changed by this statement to comply with the law.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WYOMING AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to the insurance provided by the policy under the Voluntary Compensation and Employers Liability Coverage Endorsement because Wyoming is shown as the State of Employment.

Part Two - Employers Liability Insurance

B. We Will Pay

This section is amended by adding as a final paragraph:

If any employee of a corporate insured or partnership named in the information page sustains injury to which the Wyoming Workers Compensation Act and this policy apply, the company will pay on behalf of an officer, director or shareholder, acting as an employee of such insured, all sums such officer, director and/or shareholder shall become legally obligated to pay as damages because of such injury.

D. We Will Defend

This section is amended by deleting the last sentence and adding:

The tender of the policy limits before judgment or settlement does not relieve the company of its duty to defend.

Part Six – Conditions

D. Cancellation

This section is amended to read:

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancellation is to take effect.
2. We may cancel this policy. If the policy has been in effect for 60 days or more, or is a renewal of a previously existing policy for a term longer than 60 days, we may cancel only for one of the following reasons:
   a. Failure to pay premium when due.
   b. The policy was issued because of a material misrepresentation of fact.
   c. There is a substantial change in the risk assumed, except to the extent that we should have reasonably foreseen or contemplated the change at the time that the policy was written.
   d. There is a substantial breach of contractual duties, conditions or warranties.

3. We will deliver to you and your agent, or mail to you and your agent, written notice of cancellation at your last known address. Proof of mailing shall be sufficient proof of notice.
4. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least 10 days before the cancellation is to take effect. If we cancel for any other reason, except a material misrepresentation of fact, we will mail the notice of cancellation not less than 45 days before the cancellation is to take effect. Our notice will state the reasons for cancellation.

Nonrenewal

We may elect not to renew the policy. We will deliver to you and your agent, or mail to you and your agent, written notice at your last known address, not less than 45 days prior to the expiration or anniversary date of the policy. Our notice of nonrenewal will state the reasons for nonrenewal.

All of the terms and conditions of the policy apply to the coverage afforded by this endorsement.

Nothing herein contained shall be held to vary, waive, alter or extend any of the terms, conditions, agreements or declarations of the policy, other than as herein stated.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MICHIGAN AMENDATORY ENDORSEMENT

Notice given by or on behalf of the insured to our authorized agent, with particulars sufficient to identify the insured, shall be considered notice to us.

Failure to give any notice required by this Condition within the time period specified shall not invalidate any claim made by you if it shall be shown not to have been reasonably possible to give notice within the prescribed time period and that notice was given as soon as was reasonably possible.

EXTENSION OF THE INFORMATION PAGE - ITEM 3.A - STATES COVERED

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

Item 3.A. of the Information Page is completed to include the following states:

GEORGIA	GA (SP0)	NEW HAMPSHIRE	NH (SP0)
IDAHO	ID (SP0)	NEW JERSEY	NJ (SP0)
ILLINOIS	IL (SP0)	NEW MEXICO	NM (SP0)
INDIANA	IN (SP0)	NEW YORK	NY (SP0)
IOWA	IA (SP0)	NORTH CAROLINA	NC (SP0)
KANSAS	KS (SP0)	OKLAHOMA	OK (SP0)
KENTUCKY	KY (SP0)	OREGON	OR (SP0)
MARYLAND	MD (SP0)	PENNSYLVANIA	PA (SP0)
MASSACHUSETTS	MA (SP0)	SOUTH CAROLINA	SC (SP0)
MICHIGAN	MI (SP0)	SOUTH DAKOTA	SD (SP0)
MINNESOTA	MN (SP0)	TENNESSEE	TN (SP0)
MISSISSIPPI	MS (SP0)	TEXAS	TX (SP0)
MISSOURI	MO (SP0)	VIRGINIA	VA (SP0)
MONTANA	MT (SP0)	WEST VIRGINIA	WV (SP0)
NEBRASKA	NE (SP0)	WISCONSIN	WI (SP0)
NEVADA	NV (SP0)	WYOMING	WY (SP0)

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D. - ENDORSEMENTS

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

Item 3.D. of the Information Page is completed to include the following endorsements:

WC 00 03 11	WC 00 04 03	WC 00 04 21C
WC 00 04 22A	WC 02 04 01C	WC 04 04 22
WC 09 04 03A	WC 10 04 02	WC 20 01 01
WC 20 03 03D	WC 21 03 03A	WC 35 03 03
WC 42 04 03A	WC 99 00 38F	WC 99 03 23
WC 99 03 68	WC 99 03 67	G33360
WC 00 04 14	WC 00 04 19	WC 02 06 01
WC 03 06 01A	WC 04 03 01	WC 04 03 60A
WC 04 04 21	WC 04 06 01A	WC 05 04 02
WC 06 03 01	WC 06 03 03C	WC 06 06 01
WC 09 03 03	WC 09 06 06	WC 10 06 01A
WC 11 04 02A	WC 12 03 06A	WC 12 06 01D
WC 15 04 01A	WC 15 06 01A	WC 16 03 05
WC 16 06 01	WC 16 06 02	WC 19 06 01E
WC 20 03 01	WC 20 03 02A	WC 20 04 01
WC 20 04 05	WC 20 06 01A	WC 21 03 04
WC 22 00 00A	WC 22 06 01D	WC 24 04 06C
WC 24 06 01B	WC 24 06 02B	WC 24 06 04
WC 25 03 05	WC 25 06 01A	WC 25 06 02
WC 26 06 01C	WC 27 06 01C	WC 28 04 02A
WC 28 06 01	WC 28 06 04	WC 29 03 06B
WC 29 06 03	WC 30 06 01	WC 31 03 08
WC 31 03 19F	WC 32 03 01B	WC 35 06 01E
WC 35 06 03	WC 35 06 04	WC 36 04 06
WC 36 06 01E	WC 37 04 05	WC 37 06 01
WC 37 06 02	WC 37 06 03A	WC 40 06 01A
WC 40 06 05B	WC 42 03 01F	WC 42 04 07
WC 45 06 02	WC 47 03 01A	WC 47 03 02

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D. - ENDORSEMENTS

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

Item 3.D. of the Information Page is completed to include the following endorsements:

WC 47 06 01	WC 48 06 01C	WC 48 06 06B
WC 66 02 72	WC 66 02 77A	WC 99 00 69
WC 99 00 88A	WC 99 01 02	WC 99 02 77
WC 99 02 78	WC 99 03 12	WC 99 03 55
WC 99 03 60	WC 99 03 61	WC 99 03 71
WC 99 03 74	WC 99 03 75	PN 04 99 01D
PN 04 99 02B	PN 04 99 04	PN 04 99 06
WC 66 02 81C	WC 66 03 06	

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

INSTALLMENT PREMIUM ENDORSEMENT

IT IS HEREBY UNDERSTOOD AND AGREED THAT THE ESTIMATED ADVANCE PREMIUM OF $1,297,105 WILL BE PAYABLE IN INSTALLMENTS AS OUTLINED IN SCHEDULE OF PAYMENTS.

SCHEDULE OF PAYMENTS

NO	DUE DATE OF PAYMENT	ESTIMATED ADVANCE PREMIUM
01	10/01/13	324,304
02	11/01/13	108,089
03	12/01/13	108,089
04	01/01/14	108,089
05	02/01/14	108,089
06	03/01/14	108,089
07	04/01/14	108,089
08	05/01/14	108,089
09	06/01/14	108,089
10	07/01/14	108,089

Nothing herein contained shall be held to vary, waive, alter or extend any of the terms, conditions, agreements or information of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____
Authorized Agent

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

THE POLICY IS AMENDED TO PROVIDE COVERAGE BY THE FOLLOWING INSURERS IN THE FOLLOWING JURISDICTIONS:

INSURER		JURISDICTION
HARTFORD CASUALTY INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	14397	KS MI NE PA
HARTFORD UNDERWRITERS INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	10456	AL CO CT IL MS NH OK VA WV
TWIN CITY FIRE INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	14974	AR CA FL ID IN IA KY MD MA MN MT NV NJ NM NC OH OR SC SD WA WI WY
SENTINEL INSURANCE COMPANY, LIMITED ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	13161	TN TX
HARTFORD INSURANCE COMPANY OF THE MIDWEST ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	20605	GA
PROPERTY & CASUALTY INS CO. OF HARTFORD ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	30147	AZ MO NY

THE COVERAGE PROVIDED IN EACH JURISDICTION IS WITH RESPECT TO THE LOCATIONS OF THE NAMED INSURED IN THAT JURISDICTION IN ACCORDANCE WITH THE WORKERS' COMPENSATION LAW OF THAT JURISDICTION. AS USED IN THIS POLICY, "COMPANY," "WE," "US" AND "OUR" MEAN THE MEMBER INSURANCE COMPANIES OF THE HARTFORD INSURANCE GROUP COLLECTIVELY PROVIDING THIS INSURANCE.

Nothing herein contained shall be held to vary, waive, alter or extend any of the terms, conditions, agreements or information of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____
Authorized Agent

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

F

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

INSTALLMENT PREMIUM ENDORSEMENT

IT IS HEREBY UNDERSTOOD AND AGREED THAT THE ESTIMATED ADVANCE PREMIUM OF $1,297,105 WILL BE PAYABLE IN INSTALLMENTS AS OUTLINED IN SCHEDULE OF PAYMENTS.

SCHEDULE OF PAYMENTS

NO	DUE DATE OF PAYMENT	ESTIMATED ADVANCE PREMIUM
01	10/01/13	324,304
02	11/01/13	108,089
03	12/01/13	108,089
04	01/01/14	108,089
05	02/01/14	108,089
06	03/01/14	108,089
07	04/01/14	108,089
08	05/01/14	108,089
09	06/01/14	108,089
10	07/01/14	108,089

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or information of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersignature on the Information Page of said policy by a duly authorized agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

F

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

THE POLICY IS AMENDED TO PROVIDE COVERAGE BY THE FOLLOWING INSURERS IN THE FOLLOWING JURISDICTIONS:

INSURER		JURISDICTION
HARTFORD CASUALTY INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	14397	KS MI NE PA
HARTFORD UNDERWRITERS INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	10456	AL CO CT IL MS NH OK VA WV
TWIN CITY FIRE INSURANCE COMPANY ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	14974	AR CA FL ID IN IA KY MD MA MN MT NV NJ NM NC OH OR SC SD WA WI WY
SENTINEL INSURANCE COMPANY, LIMITED ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	13161	TN TX
HARTFORD INSURANCE COMPANY OF THE MIDWEST ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	20605	GA
PROPERTY & CASUALTY INS CO. OF HARTFORD ONE HARTFORD PLAZA, HARTFORD, CONNECTICUT 061	30147	AZ MO NY

THE COVERAGE PROVIDED IN EACH JURISDICTION IS WITH RESPECT TO THE LOCATIONS OF THE NAMED INSURED IN THAT JURISDICTION IN ACCORDANCE WITH THE WORKERS' COMPENSATION LAW OF THAT JURISDICTION. AS USED IN THIS POLICY, "COMPANY," "WE," "US" AND "OUR" MEAN THE MEMBER INSURANCE COMPANIES OF THE HARTFORD INSURANCE GROUP COLLECTIVELY PROVIDING THIS INSURANCE.

Nothing herein contained shall be held to vary, waive, alter, or extend any of the terms, conditions, agreements or information of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersignature on the Information Page of said policy by a duly authorized agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

1. Rates and Premium

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

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

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

2. Payroll Audits

   You may request a payroll audit once each calendar year. Your request must be in writing, sent to our address shown in this endorsement.

   You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

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

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

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Company Address
THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA CANCELLATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

D. Cancellation

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

2. We may cancel this policy if you fail to pay premium when due. We must mail or deliver to you and the Industrial Commission of Arizona not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARKANSAS AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**
Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Part Two - Employers Liability Insurance

C. Exclusions

2. Is replaced by:

punitive or exemplary damages because of bodily injury to an employee employed in violation of law; punitive or exemplary damages are defined by Arkansas Bulletin No. 4-82 as those damages which are imposed to punish a wrongdoer and to deter others from similar conduct;

Part Six - Conditions

D. Cancellation is replaced by:

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

2. We may cancel this policy. If we cancel because you fail to pay all premiums when due, we will mail or deliver to you and to the Arkansas Workers Compensation Commission not less than 10 days advance written notice stating when the cancellation is to take effect. If we cancel for any other reason, we will mail or deliver to you and to the Arkansas Workers Compensation Commission not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient notice.

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICY AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

1. **Minors Illegally Employed - Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.
2. **Punitive or Exemplary Damages - Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.
3. **Increase in Indemnity Payment - Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars ($100).

   If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.
4. **Application of Policy.** Part One, "Workers Compensation Insurance", A, "How This Insurance Applies", is amended to read as follows:

   This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in

Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.

6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.

7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.

8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:

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

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

   a. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
   b. If you cancel, final premium may be more than pro rata; it will be based on the time this policy was in force, and may be increased by our short-rate cancelation table and procedure. Final premium will not be less than the pro rata share of the minimum premium.

It is further agreed that this policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in this policy or such endorsements shall affect such contract or any rights, duties, or privileges arising therefrom.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

A. How This Insurance Applies

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

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

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

1. Exclusion 1 is amended to read as follows:
   1. liability assumed under a contract.
2. Exclusion 2 is deleted.
3. Exclusion 7 is amended to read as follows:
   7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.
4. The following exclusions are added:
   1. bodily injury to any member of the flying crew of any aircraft.
   2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

You must provide us, or our authorized representative, access to records necessary to perform a payroll verification audit. If you fail to provide access within 90 days after expiration of the policy, you are liable to pay a total premium equal to 3 times our current estimate of the annual premium for your policy. In addition, if you fail to provide access after our third request within a 90 day or longer period, you are also liable for our costs in attempting to perform the audit unless you provide a compelling business reason for your failure.

We will contact you to schedule appointments during normal business hours.

We will notify you of your failure to provide access by mailing a certified, return-receipt document stating the increased premium and the total amount of our costs incurred in our attempt(s) to perform an audit. In addition to any other obligations under this contract, 30 days after you receive the notification, you will be obligated to pay the total premium and costs referenced above. If, thereafter, you provide access to your records within three years after the policy expires, or within another mutually agreed upon time, and we succeed in performing the audit to our satisfaction, we will revise your total premium and the costs due to reflect the results of the audit.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA CANCELLATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The cancellation condition in Part Six (Conditions) of the policy is replaced by these conditions:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy for one or more of the following reasons:
   a. Non-payment of premium;
   b. Failure to report payroll;
   c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
   d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
   e. Material misrepresentation made by you or your agent;
   f. Failure to cooperate with us in the investigation of a claim;
   g. Failure to comply with Federal or State safety orders;
   h. Failure to comply with written recommendations of our designated loss control representatives;
   i. The occurrence of a material change in the ownership of your business;
   j. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
   k. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
   l. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Informati on Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Item (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of cancellation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
4. The policy period will end on the day and hour stated in the cancellation notice.

Countersigned by: _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COLORADO CLASSIFICATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Colorado is shown in Item 3.A. of the Information Page.

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassi fication was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph :

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

Section A, 'How This Insurance Applies' of Part One, 'Workers Compensation Insurance,' is amended to read as follows:

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

(1) Injury by accident must occur during the policy period.

(2) Injury by disease must be caused or aggravated by exposure during the policy period to conditions of your employment.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to the insurance provided by Part One (Workers' Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

THE AMOUNT SHOWN ON THE INFORMATION PAGE FOR THE CONNECTICUT SECOND INJURY FUND SURCHARGE IS REQUIRED OF YOU UNDER CONNECTICUT REGULATIONS TO FINANCE THE CONNECTICUT SECOND INJURY FUND. WE WILL PAY THIS SURCHARGE TO THE CONNECTICUT STATE TREASURER.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

F. Nonrenewal

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you via registered mail, certified mail or by mail evidenced by a certificate of mailing, or deliver to the named insured at the address shown in the policy, at least sixty (60) days advance notice of our intention not to renew.

Mailing such notice to you at your address, shown in Item 1. of the Information Page, will be deemed sufficient notice under this section.

The notice of intent not to renew will state or be accompanied by a statement specifying the reason for such nonrenewal.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GEORGIA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

D. Cancellation, Nonrenewal and Change

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect, subject to the following:
   a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.
   b. If by statute, regulation or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days notice to you and the third party as soon as practicable after receiving your request for cancellation.

      Our notice will state the effective date of cancellation, which will be the later of the following:
      1) 10 days from the date of mailing or delivering our notice, or
      2) The effective date of cancellation stated in your notice to us.
2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium or if we nonrenew this policy, we must send to you a notice of cancellation or nonrenewal by certified mail, return receipt requested, to your last address of record at least 75 days prior to the effective date of cancellation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase due to change in risk, exposure or experience modification or resulting from an audit of auditable coverages), limit or restrict coverage, we must mail by first class mail or deliver a notice of our action (including dollar amount of any increase in renewal premium more than 15%) to you at the last mailing address of record at least 45 days before the expiration date of this policy.
4. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IDAHO ALCOHOL AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The Idaho Department of Insurance has approved the use of up to a 5% premium credit in the voluntary market and a flat 5% premium credit in the assigned risk market if you have established and maintain a qualifying alcohol and drug-free workplace program.

We will determine your eligibility for this premium credit either during the policy period or at the time your final premium audit is processed.

To allow a credit, we must receive a written statement from you certifying that you have established and maintain an alcohol and drug-free workplace program. Your program must meet the requirements of Sections 72-1701 through 72-1715 of the Idaho Code. We have the right to require additional information to verify that you have established and maintain a quality program.

The determination that you have a qualifying program must be made each year that you receive the premium credit.

Minimum premium policies are not eligible for this premium credit.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ILLINOIS WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

C. Change Part Two – C. Exclusions 1. as follows:

This insurance does not cover

1. liability assumed under a contract, and/or any agreement to waive your right to limit your liability for contribution to the amount of benefits payable under the Workers Compensation Act and the Workers Occupational Disease Act. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ILLINOIS AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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 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 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. PLEASE READ IT CAREFULLY.

KANSAS FINAL PREMIUM ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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. PLEASE READ IT CAREFULLY.

KANSAS CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The **Cancellation** Condition of the policy is replaced by these two Conditions:

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. 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 cancellation 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 cancellation 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 cancellation will state our reasons for canceling.
5. The policy period will end on the day and hour stated in the cancellation 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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KENTUCKY PART ONE WORKERS' COMPENSATION INSURANCE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

F. Payments You Must Make

3. you fail to comply with a health or safety law or regulation; provided that, however, we are responsible for payment of any amounts in excess of the benefits regularly provided under the workers compensation law of this state if an accident is caused in any degree by the intentional failure of the employer to comply with any specific statute or lawful administrative regulation made thereunder, communicated to the employer and relative to the installation or maintenance of safety appliances or methods as provided in KRS 342. 165(1); or

Except for any payments for which we are responsible as provided in Section F.3. above, if we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KENTUCKY CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Cancellation

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

Countersigned by _____

Authorized Representative

Form WC 16 06 01 Printed in U.S.A.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

NOTICE OF YOUR RIGHTS

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

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

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

D. Cancellation and Nonrenewal

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

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

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

b. If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service upon you, not less than thirty (30) days advance written notice stating when the cancellation or nonrenewal will take effect.

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

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

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

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS - ASSESSMENT CHARGE

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

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

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS PENDING PREMIUM CHANGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

PART FIVE
PREMIUM

D. Premium Payments is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The audit and retrospective premiums shall be paid by the due date indicated on the billing statement.**

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

D. **Cancellation and Nonrenewal**

1. You may cancel this policy.

   If you cancel this policy, you must mail or deliver advance written notice to us stating when the cancellation is to take effect.

2. We may cancel this policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. We may refuse to renew this policy.

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

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

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

(d) Any nonrenewal attempted or made that is not in compliance with paragraphs (1), (b) and (c) is not effective. Paragraphs (1), (b) and (c) do not apply if you have obtained insurance elsewhere, have accepted replacement coverage, or have requested or agreed to nonrenewal.

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

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

6. We will also send copies of the notice required by this endorsement to the agent or broker of record, though failure to send copies of the notice to the agent or broker of record will not invalidate a cancellation or nonrenewal. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this paragraph.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SOUTH DAKOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy.
   a. We must file a notice of intention in the office of the State Department of Labor or other officer in charge of the administration of the workers compensation law at least 10 days prior to cancellation due to nonpayment of premiums. Any policy cancelled for reasons other than nonpayment requires at least 20 days notification before the effective cancellation date. This notice of intention must state the date of cancellation.
   b. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation due to nonpayment of premiums is to take effect. Any policy cancelled for reasons other than nonpayment of premium requires at least 20 days written notification before effective cancellation date.
   c. Mailing that notice to you at your last known place of residence will be sufficient to prove notice.
   d. If the employer is a partnership, the notice may be given to any one of the partners.
   e. If the employer is a corporation, the notice may be given to any agent or officer of the corporation upon whom legal process may be served.
3. After sixty days from the effective date of policy issuance, a notice of cancellation may not be issued unless it is based upon at least one of the following reasons:
   a. Nonpayment of premium
   b. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Discovery of acts or omissions on the part of the named insured that increase any hazard insured against
   d. The occurrence of a change in the risk that substantially increases any hazard insured against after insurance coverage has been issued
   e. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof that substantially increases any hazard insured against

f. A determination by the director of the Division of Insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state

g. Violation or breach by the insured of any policy terms or conditions

h. Such other reasons as are approved by the director of the Division of Insurance

4. The policy period will end on the day and hour stated in the cancellation notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

Nonrenewal

1. We may elect not to renew. We will mail or deliver to you and your agent not less than 60 days advance written notice stating our intention not to renew this policy. Mailing notice to you at your last known address will be sufficient to prove notice.
2. A notice of nonrenewal is not required if the policyholder is transferred to an insurer that is a member of the same insurance group as the previous insurer and notice of such transfer is given in the form adopted by rule by the Division of Insurance.
3. The policy provisions control if the policy provides for a notice of refusal to renew that exceeds 60 days.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect. If you purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.

2. We may cancel the policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:

   a. you fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;

   b. a material misrepresentation;

   c. a substantial breach of the obligations, conditions or warranties under the policy; or

   d. a substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.

3. If we cancel for any permissible reason other than nonpayment of premium when due, we must deliver or mail, first class, not less than* thirty (30) days notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than* sixty (60) days advance written notice stating our intention not to renew this policy.

2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.

3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year, whichever is less.

4. If we offer to renew the insurance on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policy holder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after the notice is mailed or delivered, in which case, you, the policy holder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and extent of the risk insured against, including, but not limited to, a change in the classifications for the business.

* Any written agreement attached to and made a part of the policy, between the insurance carrier and policyholder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

IN WITNESS CLAUSE ENDORSEMENT - ARIZONA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The In Witness clause, contained on the Policy Jacket, is revised to read:

In Witness Whereof, the Company has caused this policy to be signed by its President and Secretary.

Countersigned by: _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VIRGINIA COUNTERSIGNATURE EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Pursuant to Virginia Code §38.2-323, the following wording, as may be contained in this policy, does not apply in Virginia:

"This policy is not binding unless countersigned by our authorized representative."

"This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement."

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA COUNTERSIGNATURE EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Pursuant to A.R.S. §20-229(C), the following wording, as may be contained in this policy, does not apply in Arizona:

> "This policy is not binding unless countersigned by our authorized representative."

"This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement."

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA INSTALLMENT FEE DISCLOSURE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

A service fee of $7.00 is charged for each installment when your premium is paid in installments. The service fee is $5.00 per withdrawal when you select an electronic fund transfer payment plan. The service fee will be added to the premium amount shown on your premium billing statement.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**
Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancelation table below:

Extended Number of Days		Percent of Full Policy Premium	Extended Number of Days		Percent of Full Policy Premium	Extended Number of Days		Percent of Full Policy Premium
1	.....	5%	95-98	.....	37%	219-223	.....	69%
2	.....	6%	99-102	.....	38%	224-228	.....	70%
3-4	.....	7%	103-105	.....	39%	229-232	.....	71%
5-6	.....	8%	106-109	.....	40%	233-237	.....	72%
7-8	.....	9%	110-113	.....	41%	238-241	.....	73%
9-10	.....	10%	114-116	.....	42%	242-246	(8 mos.)	74%
11-12	.....	11%	117-120	.....	43%	247-250	.....	75%
13-14	.....	12%	121-124	(4 mos.)	44%	251-255	.....	76%
15-16	.....	13%	125-127	.....	45%	256-260	.....	77%
17-18	.....	14%	128-131	.....	46%	261-264	.....	78%
19-20	.....	15%	132-135	.....	47%	265-269	.....	79%
21-22	.....	16%	136-138	.....	48%	270-273	(9 mos.)	80%
23-25	.....	17%	139-142	.....	49%	274-278	.....	81%
26-29	.....	18%	143-146	.....	50%	279-282	.....	82%
30-32	(1 mo.)	19%	147-149	.....	51%	283-287	.....	83%
33-36	.....	20%	150-153	(5 mos.)	52%	288-291	.....	84%
37-40	.....	21%	154-156	.....	53%	292-296	.....	85%
41-43	.....	22%	157-160	.....	54%	297-301	.....	86%
44-47	.....	23%	161-164	.....	55%	302-305	(10 mos.)	87%
48-51	.....	24%	165-167	.....	56%	306-310	.....	88%
52-54	.....	25%	168-171	.....	57%	311-314	.....	89%
55-58	.....	26%	172-175	.....	58%	315-319	.....	90%
59-62	(2 mos.)	27%	176-178	.....	59%	320-323	.....	91%
63-65	.....	28%	179-182	(6 mos.)	60%	324-328	.....	92%
66-69	.....	29%	183-187	.....	61%	329-332	.....	93%
70-73	.....	30%	188-191	.....	62%	333-337	(11 mos.)	94%
74-76	.....	31%	192-196	.....	63%	338-342	.....	95%
77-80	.....	32%	197-200	.....	64%	343-346	.....	96%
81-83	.....	33%	201-205	.....	65%	347-351	.....	97%
84-87	.....	34%	206-209	.....	66%	352-355	.....	98%
88-91	(3 mos.)	35%	210-214	(7 mos.)	67%	356-360	.....	99%
92-94	.....	36%	215-218	.....	68%	361-365	(12 mos.)	100%

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MICHIGAN LAW ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

1. We are "the insurer issuing this policy"
2. You are "the insured employer"
3. "Michigan workmen's compensation act" means the Workers' Disability Compensation Act of 1969
4. "Workmen's compensation" means workers compensation
5. "The bureau of workmen's compensation" means the Bureau of Workers' Disability Compensation

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

Compensation

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

Medical Services

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

Rehabilitation Services

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

Funeral Expenses

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

Scope of Contract

e. That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations Assumed

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

Termination Notice

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

Conflicting Provisions

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

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MINNESOTA AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

E. We will Also Pay is amended to read:

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

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. your share of pre-or postjudgment interest assuming that the principal amount of that judgment is within the applicable policy limits under this insurance; and
5. expenses we incur.

H. Recovery From Others is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for an injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

PART FIVE - PREMIUM

G. Audit is amended to read:

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data.

We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends, except as it pertains to Part Two - Employers' Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

DEFINITIONS

As used in this policy " rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Cancellation of a New Policy

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of cancellation.

Cancellation of Other Policies

If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

Notice of Cancellation

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or delivered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.

Refunds Due You

If this policy is cancelled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

1. Insured elsewhere;
2. Accepted replacement coverage; or
3. Requested or agreed not to renew this policy.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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 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.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MISSOURI CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Cancellation

1. You may cancel this policy. 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 or deliver to you not less than 60 days advance written notice stating when the cancellation is to take effect and our reason for cancellation. 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 cancellation 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 cancellation 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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOCIATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

   b. 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.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MISSOURI AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MONTANA INTENTIONAL INJURY EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Exclusion 5 of Section C — Exclusions of Part Two (Employers Liability Insurance) of the policy is replaced by the following exclusion:

C. Exclusions

This insurance does not cover:

5. bodily injury caused by your intentional, malicious or deliberate act, whether or not the act was intended to cause injury to the employee injured, or whether or not you had actual knowledge that an injury was certain to occur.

Countersigned by: _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MONTANA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

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 or deliver to you and to the Workers Compensation Division not less than 20 days advance written notice stating when the cancellation 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 60 days or more, we may cancel only for one of the following reasons:
   a. A nonpayment of premium;
   b. A material misrepresentation;
   c. A substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or contemplate the risk when we issued the policy;
   d. A substantial breach of the duties, conditions or warranties under the policy;
   e. The Commissioner has determined that continuation of the policy would place us in violation of the laws of Montana;
   f. We are financially impaired; or
   g. Any other reason that is approved by the Commissioner.
4. Our notice of cancellation will state our reasons for cancelling.

Nonrenewal

1. We may elect not to renew. We will mail or deliver to you and your agent not less than 45 days advance written notice stating our intention not to renew this policy. Mailing notice to you at your last known address will be sufficient to prove notice.
2. We do not have to renew the policy if you are insured elsewhere, accept replacement insurance or request or agree to nonrenewal or if the policy is expressly designated as being nonrenewable.
3. Our notice of nonrenewal will state our reasons for not renewing.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MONTANA SAFETY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to the insurance provided by the Policy because insurance is provided to you in Montana.

You must establish and administer an education-based safety program for all employees including temporary workers. The program shall consist of a safety training program which includes new employee general safety orientation, job- or task-specific safety training, and continuous refresher safety training encompassing periodic safety meetings. The education-based safety program will also include periodic hazard assessments, with corrective actions identified, and appropriate documentation of performance of the activities.

If you have more than five employees, then you must have a comprehensive and effective safety program which has a safety committee, established procedures for reporting and investigating all work-related incidents, accidents, injuries, and illnesses, and established procedures that assign specific safety responsibilities and safety performance accountability.

We must provide safety consultation services to you which include consideration of the hazard, experience, and the size of your operations. We will notify you of the type of safety consultation services available and the location where the safety consultation services may be requested. If we furnish or fail to furnish safety consultation services related to, in connection with, or incidental to providing workers compensation, we are not responsible for damages from any injury, loss, or death occurring as a result of any act of omission by us, our employees or our service contractors in the course of providing safety consultation services to you.

However, we may be responsible for any safety consultation services required to be performed under the provisions of a written service contract for which a specific charge is made and not incidental to a policy of insurance; for damages caused by our actions or omission to act in which it was judicially determined that the act or omission constituted a crime or involved actual malice; or if the injury, loss, or death occurred during the actual performance of safety consultation services and was directly and proximately caused by us.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEBRASKA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

1. You may cancel this policy within the policy period by giving notice to us, fixing the date on which the cancellation 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 cancellation shall not be effective until ten (10) days after the mailing of the notice to the Nebraska Workers' Compensation Court that the policy is being canceled. However, if you have secured insurance with another insurer, the cancellation 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 to you and to the Nebraska Workers' Compensation Court, fixing the date on which the cancellation or nonrenewal is to be effective.

6. The notice from us will contain a brief statement of the reasons for cancellation 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 to the Nebraska Workers' Compensation Commission.

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

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

A. Midterm Cancellation

1. You may cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect.
2. We will provide you not less than 10 days notice if this policy is cancelled because you failed to pay a premium or remit an amount due because of an endorsement for a deductible when due.
3. We will provide you not less than 30 days notice for any other cancellation reason permitted under Nevada law, including failure to pay additional premium charged due to an audit of any payroll under the terms of the current or previous policy.
4. No policy of industrial insurance that has been in effect for at least 70 days or that has been renewed may be cancelled, except on any one of the following grounds:
   a. A failure by the policyholder to pay a premium for the policy of industrial insurance when due, including the failure of the policyholder to remit an amount due because of an endorsement for a deductible;
   b. A failure by the policyholder to:
      (1) Report any payroll;
      (2) Allow the insurer to audit any payroll in accordance with the terms of the policy or any previous policy issued by the insurer; or
      (3) Pay any additional premium charged because of an audit of any payroll as required by the terms of the policy or any previous policy issued by the insurer;
   c. A material failure by the policyholder to comply with any federal or state order concerning safety or any written recommendation of the insurer's designated representative for loss prevention;
   d. A material change in ownership of the policyholder or any change in the policyholder's business or operations that:
      (1) Materially increases the hazard for frequency or severity of loss;
      (2) Requires additional or different classifications for the calculation of premiums; or
      (3) Contemplates an activity that is excluded by any reinsurance treaty of the insurer;

e. A material misrepresentation made by the policyholder; or

f. A failure by the policyholder to cooperate with the insurer in conducting an investigation of a claim.

5. We cannot cancel the policy when the referenced reasons are corrected by you within the time specified in the written notice of cancellation.

B. Nonrenewal

1. We may elect not to renew the policy. We will provide to you a written notice of our intention not to renew at least 60 days before the expiration date.
2. We need not provide notice of our intention not to renew if you have accepted replacement coverage, if you have requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

C. Information About Claims Paid

1. If you request information for the renewal of the policy, we will provide you with information regarding claims paid on your behalf.
2. We will provide the information within 30 working days after we receive your written request. We may charge a reasonable fee for providing the information.

D. Notices

1. We will provide advance written notice of cancellation or nonrenewal as provided in A and B above. This notice must be served personally on or sent by first-class mail or electronic transmission to the employer.
2. Notices will state the effective date of the cancellation or nonrenewal and will be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal.
3. A written notice of cancellation is not required if we mutually agree with you to cancel the policy and reissue a new policy based upon a material change in ownership or operation of your business.

E. Compliance with Law

1. Any of these provisions that conflict with a law that controls the cancellation or renewal or nonrenewal of the insurance in this policy is changed by this statement to comply with the law.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE CERTIFIED MANAGED CARE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

You may receive up to a ten percent (10%) premium credit if you subscribe to the services of an approved Managed Care Program.

In order to receive this credit, you are enrolled by your insurance company or subscribe individually to obtain the services of a Certified Managed Care Program. Certified Managed Care Programs are programs that are approved by the New Hampshire Department of Labor and ratified by the New Hampshire Advisory Council on Workers Compensation.

The managed care credit is to be applied in a multiplicative manner, after application of the experience modification factor. Also, all other credits/debits must be applied in a multiplicative manner, after the application of the experience modification factor and the managed care credit and before the application of the expense constant or premium discount, if any.

The credit can only be issued at inception of the policy. Minimum premium policies are not eligible for this credit. The credit is not applicable to assigned risk policies.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE SOLE REPRESENTATIVE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Condition E, "Sole Representative," of the policy is replaced by the following:

"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. If we cancel this policy, we will give each named insured notice of cancellation."

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

For New Hampshire coverage, the Cancellation condition of the policy is amended and replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us.
2. We may cancel this policy. We will file a written termination notice with the Commissioner of the Department of Labor and will send a copy to you.
3. In case of nonpayment of premium, the cancellation will take effect 30 days after the termination notice is filed.
4. In case of cancellation for reasons other than nonpayment of premium, cancellation will take effect 45 days after the notice of termination is filed.
5. If you have obtained coverage from another insurance carrier or have qualified as a self-insurer, cancellation is effective on the date you obtained the coverage or qualified as a self-insurer.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

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

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

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

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

F. Other Insurance

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

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW JERSEY PARTICIPATING PROVISION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

You may be entitled to participate in a distribution of the surplus or excess premium of the company to such extent and upon such conditions as shall be determined by the board of directors of the company provided you have complied with all the terms of the policy including the payment of premiums.

Neither dividends nor any factors used in their calculation may be guaranteed.

Dividends will be payable only for a policy period that has expired.

By the purchase of this policy you do not obtain any contractual right to a dividend.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW MEXICO CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Cancellation
You may cancel this policy by returning it to us or by giving us a written notice and stating at what future time coverage is to cease.

We may cancel this policy, or one or more of its parts, by giving you a written notice. If the premium has not been paid when due, we may cancel at any time by giving the required notice at least 10 days before the cancellation is effective.

If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel by giving the required notice at least 10 days before the cancellation is effective.

If the policy has been in effect for 60 days or more or is a renewal, we may cancel only for one or more of the following reasons:

a. The policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by us;

b. Willful and negligent acts or omissions by the insured have substantially increased the hazards insured against;

c. You presented a claim based on fraud or material misrepresentation; or

d. There has been a substantial change in the risk assumed by us since the policy was issued.

We will give the required Notice of Cancellation stating the reason(s) for cancellation at least 30 days before the cancellation is effective. The notice will state the time that the cancellation is to take effect. The notice will be sent to your mailing address last known to us.

Your return premium, if any, will be calculated as follows:

a. If we cancel, we will return all unearned premiums.

b. If you cancel, the refund will be calculated according to our rules.

Your return premium will be refunded to you with the cancellation notice or within a reasonable time. Payment or tender of the unearned premium is not a condition of cancellation.

Nonrenewal
If we decide not to renew this policy, we must give you written notice of our intention not less than 30 days prior to the expiration of the policy.

This nonrenewal section does not apply to any policy of insurance issued to an insured who has its principal place of business outside this state.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is amended by adding the following provision:

5. If this policy has been in effect for more than 45 business days or is a renewal policy, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted under it;
   c. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;
   d. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;
   e. A violation of local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;
   f. A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;
   g. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or
   h. Loss of or substantial changes in applicable reinsurance.

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

F. Nonrenewal

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

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

Any notice of nonrenewal will be mailed or delivered to you at the last mailing address known to us.

If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.
b. Proof of mailing will be sufficient proof of notice.

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

We will not provide notice of nonrenewal if:

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

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

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

G. Notice of Premium or Coverage Changes Upon Renewal

If we elect to renew this policy, we will give written notice of any premium increase, change in deductible, or reduction in limits or coverage, to you, at the last mailing address known to us.

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

a. The expiration date of this policy; or

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

If notice is mailed:

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

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

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

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

a. 45 days after notice is given; or

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

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

We will not provide notice of the following:

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

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

c. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA FRAUD WARNING ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA ELECTION OF COVERAGE NOTIFICATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

NOTICE: YOU HAVE THE OPTION TO ELECT TO INCLUDE, AS APPLICABLE, YOUR SOLE PROPRIETOR, ANY OR ALL OF YOUR PARTNERSHIP MEMBERS, ANY OR ALL OF YOUR LIMITED LIABILITY COMPANY MEMBERS, OR ANY OR ALL OF YOUR STOCKHOLDER-EMPLOYEES AS EMPLOYEES FOR THE PURPOSE OF WORKERS COMPENSATION INSURANCE COVERAGE BY ENDORSING THE POLICY IN ACCORDANCE WITH SECTION 3 OF TITLE 85 OF THE OKLAHOMA STATUTES.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OREGON PREMIUM DUE DATE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

PART FIVE
PREMIUM

D. Premium is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. The due date for audit and retrospective premiums is the date specified in the billing invoice for that policy.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OREGON CANCELLATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

D. **Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancellation is to take effect. If you provide for other insurance or self-insurance, your cancellation of coverage will take effect upon the effective date of that insurance.
2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.
   a) If we cancel, based on our decision not to offer insurance to all employers within your premium category, we will mail the notice of cancellation at least 90 days before the cancellation is to take effect.
   b) If we cancel for other reasons, we will mail the notice of cancellation at least 45 days before the cancellation is to take effect.
   c) If we cancel for nonpayment, we will mail notice of cancellation at least 10 days before the cancellation is to take place.
3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.
4. The policy period will end at 12 midnight on the day stated in the cancellation notice.
5. When coverage is placed with another carrier as of the policy expiration date, a rejected renewal policy shall be withdrawn without charge, providing notice of nonrenewal is mailed and postmarked on or before the expiration date and is received from the insured by the insurer no later than 10 calendar days after said expiration date.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENNSYLVANIA MERIT RATING PLAN ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

The premium for this insurance may be subject to merit rating because your premium may be less than the amount necessary to be eligible for the uniform Experience Rating Plan.

The following premium discount or surcharge will be applied to your manual premium based on your claims during the most recent two year period for which statistics are available.

1. A 5% credit (**discount**) will be applied if you had no compensable employee lost-time injuries -- **Statistical Code 9885**.

2. No credit or debit will be applied if you had one (1) compensable employee lost-time injury -- **Statistical Code 9884**.

3. A 5% debit (**surcharge**) will be applied if you had two (2) or more compensable employee lost-time injuries -- **Statistical Code 9886.**

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIAL PENNSYLVANIA ENDORSEMENT - INSPECTION OF MANUALS

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENNSYLVANIA NOTICE

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

An Insurance Company, its agents, employees or service contractors acting on its behalf, may provide services to reduce the likelihood of injury, death or loss. These services may include any of the following or related services incident to the application for, issuance, renewal or continuation of, a policy of insurance:

1. surveys;
2. consultation or advice; or
3. inspections.

The "Insurance Consultation Services Exemption Act" of Pennsylvania provides that the Insurance Company, its agents, employees or service contractors acting on its behalf, is not liable for damages from injury, death or loss occurring as a result of any act or omission by any person in the furnishing of or the failure to furnish these services.

The Act does not apply:

1. if the injury, death or loss occurred during the actual performance of the services and was caused by the negligence of the Insurance Company, its agents, employees or service contractors;
2. to consultation services required to be performed under a written service contract not related to a policy of insurance; or
3. if any acts or omissions of the Insurance Company, its agents, employees or service contractors are judicially determined to constitute a crime, actual malice, or gross negligence.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

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

Nonrenewal

1. We may elect not to renew the policy. We will mail each named insured, by first class mail, not less than 60 days advance notice stating when the nonrenewal will take effect. Mailing that notice to you at your mailing address last known to us will be sufficient to prove notice.
2. Our notice of nonrenewal will state our specific reasons for not renewing.
3. If we have indicated our willingness to renew, we will not send you a notice of nonrenewal. However, the policy will still terminate on its expiration date if:
   a. you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
   b. you fail to pay all premiums when due; or

c. you obtain other insurance as a replacement of the policy.

Notice of Increase in Premium

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

Return of Unearned Premium

1. If this policy is canceled and there is unearned premium due you:
   a. If the Company cancels, the unearned premium will be returned to you within 10 business days after the effective date of cancellation.
   b. If you cancel, the unearned premium will be returned within 30 days after the effective date of cancellation.

2. Because this policy was written on the basis of an estimated premium and is subject to a premium audit, the unearned premium specified in 1a. and 1b. above, if any, shall be returned on an estimated basis. Upon our completion of computation of the exact premium, an additional return premium or charge will be made to you within 15 days of the final computation.

3. These return or unearned premium provisions shall not apply if this policy is written on a retrospective rating plan basis.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SOUTH DAKOTA DIRECT ACTION STATUTE ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

1. Your injured employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.
2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of the employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct action statute (Section 58-20-12) of the South Dakota Workers Compensation Law.

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

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

The declarations section of this policy will show a credit of 0.00% if you are not eligible for this credit, of if you are eligible for this credit and have not yet applied for a credit. Credits are earned for average wages in excess of $15.50 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

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

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

POLICY EFFECTIVE DATE	THIRD QUARTER PAYROLL
4/1/09 thru 3/31/10	2008
4/1/10 thru 3/31/11	2009
4/1/11 thru 3/31/12	2010
4/1/12 thru 3/31/13	2011
4/1/13 thru 3/31/14	2012
4/1/14 thru 3/31/15	2013

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

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

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

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

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

Form WC 31 03 19 F Printed in U.S.A.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

GENERAL SECTION

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

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

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

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

PART ONE - WORKERS' COMPENSATION INSURANCE

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

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

F. **Payments You Must Make**

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

H. **Statutory Provisions**

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

PART TWO - EMPLOYERS' LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

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

Section 6 is amended to read:

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

D. **We Will Defend**

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

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

PART FIVE - PREMIUM

A. **Our Manuals** is amended by adding this sentence.

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

C. **Remuneration**

Number 2 is amended to read:

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

E. **Final Premium**

Section 2 is amended to read:

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

PART SIX - CONDITIONS

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

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

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

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

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

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

2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Workers' Compensation Commission.

3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:

   a. Fraud in obtaining coverage;

   b. Misrepresentation of the amount of payroll for purposes of premium calculation.

   c. Failure to pay a premium when payment was due;

   d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control within

   e. a reasonable period with recommendations designed to reduce a hazard that is under your control;

   f. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.

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

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. **Claims Notification**

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

We shall, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request.

The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX #(512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS EXPERIENCE RATING MODIFIER ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The premium for the policy will be adjusted by an experience rating modifier, if any, which was not available when the policy was issued. We will issue an endorsement to show the proper factor when it is calculated.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

PART FIVE - PREMIUM

D. Premium Payments

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

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VIRGINIA AMENDATORY ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

For Virginia insurance, Part Six D. (Conditions-Cancellation) is replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us. You must provide written notice of your cancellation, including the date of and reasons for the cancellation, to the Workers Compensation Commission.

2. We may cancel this policy. We will provide you with 30 days notice of cancellation. We will provide the Workers Compensation Commission with immediate notice of such cancellation. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

3. In the event of cancellation by you or us, you must provide 30 days written notice of the cancellation to your covered employees.

4. We may nonrenew your policy. We will provide 30 days notice to you and to the Workers Compensation Commission of our decision to nonrenew. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

5. If you fail to pay the premium due on this policy we may cancel the policy by providing 10 days notice to you and to the Workers Compensation Commission.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WEST VIRGINIA EMPLOYERS LIABILITY INSURANCE INTENTIONAL ACT EXCLUSION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, including your deliberate intention as that term is defined by W. Va. Code § 23-4-2(d)(2).

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WEST VIRGINIA WORKERS COMPENSATION INSURANCE RECOVERY FROM OTHERS ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

Part One—Workers Compensation Insurance, G.—Recovery From Others, is replaced by the following:

We have your rights to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WEST VIRGINIA CANCELLATION ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

Part Six, D (Conditions-Cancellation) is replaced by:

D. Cancellation

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

2. We may cancel this policy at any time by providing you thirty (30) days advance written notice.

3. Notwithstanding #2 above, if you fail to pay any premium due or refuse to comply with a premium audit under this policy, we may cancel the policy by providing you ten (10) days advance written notice.

4. We may also choose not to renew this policy by providing sixty (60) days advance written notice.

5. Our mailing of the Notice of Cancellation or Non-Renewal to your mailing address as listed in Item 1 of the information page will be sufficient notice of our intent to cancel. We will also provide notice of the cancellation or non-renewal of the policy to the West Virginia Insurance Commissioner at least ten (10) days prior to the effective date of termination, within ten (10) days of receipt of your request for cancellation, as applicable.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WISCONSIN LAW ENDORSEMENT

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

II. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all terms of this policy.

IV. If an injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDATORY ENDORSEMENT
COLORADO

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

It is agreed that this policy covers all employees of the insured, including statutory employees, and covers all business operations of the insured in any lawful endeavors, whether naturally connected or not, with respect to compensation and other benefits required of the insured by the Workers Compensation Law.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY PARTICIPATING DIVIDEND PROVISIONS

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The insurer shown on the Information Page is a stock insurer. The Policy Provisions are amended to include the following:

DIVIDEND PROVISIONS

DIVIDEND PROVISION. (Does not apply in Arkansas, California, Oregon, South Carolina or Texas). The insured shall participate in the earnings of the company, to such extent and upon such conditions as shall be determined by the Board of Directors of the company in accordance with the law and as made applicable to this policy, provided the insured shall have complied with all of the terms of this policy with respect to the payment of premium.

STATE DIVIDEND PROVISIONS

ARKANSAS PARTICIPATING PROVISIONS. The insured shall participate in the earnings of the company, to such extent and upon such conditions as shall be determined by the board of directors of the company in accordance with the law as made applicable to this policy, provided the insured shall have complied with all terms of this policy with respect to the payment of premium. Dividends are not guaranteed and must by law be paid from the surplus of the company.

CALIFORNIA PARTICIPATING PROVISIONS. The insured may be entitled to a dividend which shall represent such proportion of any distributable surplus of the Company accumulated from premiums on California Workers' Compensation policies as may be provided in such authorized dividend plan as may hereafter be adopted at the sole discretion of the Board of Directors of the Company and made applicable to this policy, such dividend to be computed and paid at such time and subject to conditions as shall be set forth in such plan and in accordance with the law after the expiration of the policy period to which the dividend is applicable, provided no dividend shall accrue or become payable hereunder:

1. If any part of the premium of this policy shall remain unpaid after written demand therefor, or in any event for a continuous period of ninety days following date of statement mailed to the insured;
2. If the insured shall fail to render every report of earnings requested by the Company or keep accurate payroll records so that the actual premium for the policy period can be determined by the Company;
3. If suit is brought by the Company for an accounting or to force collection of any part of the premium for this policy.

Under California Law it is unlawful for an insurer to promise the future payment of dividends under an unexpired workers' compensation policy or to misrepresent the conditions for dividend payment. Dividends are payable only pursuant to conditions determined by the Board of Directors or other governing board of the Company following policy expiration.

OREGON PARTICIPATING PROVISIONS. It is unlawful in Oregon for an insurer to promise to pay policyholder dividends for any unexpired portion of the policy term or to misrepresent the conditions for dividend payment. Dividends will be due and payable only for a policy period that has expired, and only if declared by and under conditions prescribed by the Board of Directors of the insurer.

SOUTH CAROLINA PARTICIPATING PROVISIONS. The insured shall participate in the earnings of the company, only in accordance with the law and with a plan applicable to this policy which has been filed with the Chief Insurance Commissioner of South Carolina, provided the insured has complied with all the terms of this policy with respect to the payment of premium.

Neither dividends nor any factor in their calculation may be guaranteed. By purchasing this policy, the insured obtains no contractual right to a dividend. Dividends are declared in the sole discretion of the governing body of the insurer, in accordance with the law. Any representations to the contrary are false.

TEXAS DIVIDEND PROVISION - PARTICIPATING COMPANIES. The named insureds shall be entitled to participate in a distribution of the surplus of the company, as determined by its Board of Directors from time to time, after approval in accordance with the provisions of the Texas Insurance Code, of 1951, as amended.

Countersigned by _____

Authorized Representative

Form WC 99 02 77 Printed in U.S.A.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY PARTICIPATING DIVIDEND PROVISIONS - FLORIDA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The insurer shown on the Information Page is a stock insurer. The Policy Provisions are amended to include the following:

DIVIDEND PROVISIONS. The insured is entitled to participate in the earnings of the company provided the insured has complied with all of the terms of the policy pertaining to payment of premium. The Board of Directors determines the extent and conditions under which the insured may participate in accordance with the applicable state law.

Dividends cannot be guaranteed. When declared by our Board of Directors they are paid from surplus. The insured is not entitled to participate in our earnings if this policy is canceled at the insured's request.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY PARTICIPATING DIVIDEND PROVISIONS - WISCONSIN

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The insurer shown on the Information Page is a stock insurer. The Policy Provisions are amended to include the following:

DIVIDEND PROVISIONS

DIVIDEND PROVISION. The insured shall participate in the earnings of the company, to such extent and upon such conditions as shall be determined by the Board of Directors of the company in accordance with the law and as made applicable to this policy. The dividend payment will be applied to offset any unpaid premiums for this policy. If the dividend exceeds the premium due the excess will be paid to the insured.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY PARTICIPATING DIVIDEND PROVISIONS - NEW YORK

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

The insurer shown on the Information Page is a stock insurer. The Policy Provisions are amended to include the following:

DIVIDEND PROVISIONS. The insured shall participate in the earnings of the company, to such extent and upon such conditions as shall be determined by the Board of Directors of the company in accordance with the law and as made applicable to this policy, provided the insured shall have complied with all of the terms of this policy with respect to the payment of premium.

Dividends may not, by law, be guaranteed in advance and can be paid only upon resolution declared by the Board of Directors.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

APPLICATION OF LIMITS OF LIABILITY ENDORSEMENT
CALIFORNIA

Policy Number: 37 WB BN3284 **Endorsement Number:**

Effective Date: 10/01/13 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: WALSWORTH PUBLISHING COMPANY, INC.

ATTN: RANDY FAY; 306 N KANSAS AVE
MARCELINE, MO 64658

This endorsement applies only to insurance provided in Part Two (Employers Liability Insurance) in the state of California.

The maximum amount we will pay for damages because of bodily injury by accident or disease, including death at any time resulting therefrom, sustained by your employees and arising out of and in the course of an employment with respect to which the injured employee and you are subject to the California Workers' Compensation Law is:

Bodily Injury by Accident:
$1,000,000 - each accident

Bodily Injury by Disease:
$1,000,000 - each employee

Bodily Injury by Disease:
$1,000,000 - policy limit

Countersigned by _____
Authorized Representative

Michigan Workers' Compensation
Managed Care Premium Credit Qualifications

This form attests to your agreement to implement and/or continue the controls checked below as a part of your organization's regular operations. By signing this form, you agree to continue the activities you have checked or notify us of your intent to discontinue such practices.

Please check those that apply:

[ ] You agree to use an approved program to return recuperating employees to work on some form of restricted work status (once authorized by a physician), until the employee can resume full employment duties. (5% credit)

[ ] You agree to report at least 80% of all workers' compensation claims within 3 working days of occurrence by using The Hartford's designated toll free telephone number. (10% credit)

[ ] You agree to conduct an injury review or accident investigation following the occurrence of a claim. (5% credit)

[ ] You agree to cooperate with managed care procedures initiated by The Hartford to direct injured employees to appropriate medical treatments, physical therapy, vocational therapy, and/or other processes deemed necessary to achieve maximum medical improvement. **Note: After 10 days from the inception of medical care, the injured employee has the right to be treated by the provider of their choice, pursuant to MCLA 418.315(1). The employer can not force injured employees to use its Designated Medical Provider after 10 days from the inception of medical care, rather it must encourage employees continued use of such services.** (10% credit)

Subject to a maximum total of 25% credit.

You also agree that The Hartford has the right to inspect your records and/or workplace(s) to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Insured's Signature: _____

Title: _____ Date: _____

Company: _____

Policy Number: 37 WB BN3284

Return to
Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE

CHARLOTTE NC 28213

$1,800 MEDICAL SERVICE DEDUCTIBLE

Oregon Administration Rule 436-060-0055 requires insurers to notify employers of their right to pay, through reimbursement, up to $1,800 in medical costs for each non-disabling workers' compensation claim, and of the responsibilities of employers and insurers under this plan. Please note that:

1. Employers are responsible for promptly reporting all claims.
2. Insurers are responsible for determining compensability, for auditing medical charges, for timely processing, and **for actual payment of all claims.**

IF YOU WISH TO PARTICIPATE

You must notify us in writing within 30 days of receiving this notice. If you do not respond, you are presumed to reject participation.

An election to participate remains in effect until you withdraw it by written notice.

IF YOU NOTIFY US YOU WISH TO PARTICIPATE

Within 30 days after the end of each month, we will send you a list of eligible claims.

Within 30 days after you receive the list, you must identify the claims and dollar amounts you want to pay, and reimburse us.

Your failure to reimburse us within 30 days will be deemed notice that you do not wish to participate for that period.

Any amounts you reimburse us will not be included in the calculation of your future experience modifiers.

WHAT EFFECT WILL IT HAVE?

You should be aware that this plan will not affect your experience rating for a minimum of two years. The effect on your experience rating may or may not offset your out-of-pocket costs.

If you are on a retrospective rating plan, the employer-paid costs **will** be included in the retrospective premium computation, **but** these amounts will be subsequently credited against the resulting retrospective premium.

Form WC 66 00 97 F Printed in U.S.A.

IMPORTANT NOTICE
GEORGIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Georgia Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for Indemnity and/or Medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.7%	0.5%	0.4%	0.4%	0.3%	0.2%	0.1%
( )	200	1.5%	1.0%	0.9%	0.7%	0.5%	0.4%	0.3%
( )	300	2.1%	1.5%	1.3%	1.0%	0.9%	0.5%	0.4%
( )	400	2.6%	1.9%	1.6%	1.3%	1.1%	0.7%	0.5%
( )	500	3.0%	2.3%	1.9%	1.6%	1.3%	0.9%	0.7%
( )	1,000	4.7%	3.7%	3.1%	2.6%	2.1%	1.5%	1.1%
( )	1,500	5.8%	4.6%	3.9%	3.3%	2.7%	1.9%	1.4%
( )	2,000	6.8%	5.4%	4.6%	3.8%	3.2%	2.3%	1.7%
( )	2,500	7.5%	6.0%	5.1%	4.3%	3.7%	2.6%	1.9%

All indemnity and/or medical claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE

CHARLOTTE NC 28213

IMPORTANT NOTICE

NEW MEXICO WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New Mexico Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to bodily injury by accident or disease.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pays all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

			A	B	C	D	E	F	G
( )	$	500	3.9%	3.0%	2.5%	2.0%	1.7%	1.2%	0.9%
( )	$	1,000	6.3%	4.8%	4.2%	3.4%	2.9%	2.0%	1.6%
( )	$	1,500	7.8%	6.1%	5.3%	4.4%	3.7%	2.6%	2.0%
( )	$	2,000	9.1%	7.1%	6.2%	5.2%	4.4%	3.1%	2.5%
( )	$	2,500	10.1%	8.0%	7.0%	5.9%	5.0%	3.6%	2.9%
( )	$	5,000	13.9%	11.2%	9.9%	8.5%	7.3%	5.5%	4.3%
( )	$	10,000	18.9%	15.5%	13.9%	12.2%	10.6%	8.2%	6.6%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Issuing Office THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

IMPORTANT NOTICE

NEBRASKA WORKERS' COMPENSATION INSURANCE
MEDICAL BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Nebraska Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	**$ 500**	3.9%	3.0%	2.5%	2.1%	1.7%	1.1%	0.8%
( )	**$1,000**	6.1%	4.8%	4.0%	3.3%	2.8%	1.9%	1.4%
( )	**$1,500**	7.5%	5.9%	5.1%	4.2%	3.5%	2.4%	1.8%
( )	**$2,000**	8.5%	6.8%	5.8%	4.9%	4.0%	2.8%	2.1%
( )	**$2,500**	9.4%	7.6%	6.5%	5.5%	4.6%	3.2%	2.4%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

IMPORTANT NOTICE

SOUTH DAKOTA WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in South Dakota Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION

MEDICAL AND INDEMNITY

HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 500	4.5%	3.5%	3.0%	2.4%	2.0%	1.3%	0.9%
( )	$ 1,000	6.8%	5.5%	4.6%	3.8%	3.2%	2.1%	1.5%
( )	$ 1,500	8.4%	6.8%	5.7%	4.8%	4.0%	2.7%	2.0%
( )	$ 2,000	9.5%	7.8%	6.6%	5.6%	4.7%	3.3%	2.4%
( )	$ 2,500	10.6%	8.7%	7.4%	6.3%	5.3%	3.7%	2.7%

MEDICAL ONLY

HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 500	4.4%	3.4%	2.9%	2.4%	2.0%	1.3%	0.9%
( )	$ 1,000	6.6%	5.3%	4.4%	3.7%	3.1%	2.1%	1.5%
( )	$ 1,500	8.0%	6.5%	5.5%	4.6%	3.8%	2.6%	1.9%
( )	$ 2,000	9.1%	7.3%	6.2%	5.2%	4.4%	3.0%	2.2%
( )	$ 2,500	10.0%	8.1%	6.9%	5.8%	4.9%	3.4%	2.5%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to

Issuing Office:

Address:

DEDUCTIBLE NOTICE OF ELECTION TO ACCEPT TEXAS WORKERS COMPENSATION BENEFITS

Texas law permits an employer to obtain Workers' Compensation insurance with a deductible. The deductible applies to benefits payable under Texas Workers' Compensation Law. The insurance applies only to benefits in excess of the deductible amount. The deductible applies separately to each accident or disease regardless of the number of people who sustain injury by such accident or disease or as an annual aggregate or as a combination of both. The deductible plans have been explained to me. Premium reductions are determined based on the deductible selected, and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

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

If a deductible amount is desired, please indicate below.

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

1. $ per accident

2. $ annual aggregate

3. $ /$ per accident/annual aggregate

applied to benefits payable under the Texas Workers' Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement

.

(monthly, quarterly or other)

( ) No, I do not want a deductible applied to benefits payable under the Texas Workers' Compensation Law

( ) Yes, I do want a deductible policy, but am unable to obtain for the following reason:

.

WALSWORTH PUBLISHING COMPANY, INC.

Employer Name (print or type)

Date

Signature and Title

37 WB BN3284

Policy Number

WC 66 01 25 Printed in U.S.A.

Process Date: 10/10/13

Policy Expiration Date: 10/01/14

IMPORTANT NOTICE

COLORADO WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY DEDUCTIBLE ELECTION FORM

Recent changes in the Colorado Workers' Compensation Law permit an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only. There are six "Per Claim" deductible options available. They are:

( ) NONE
( ) $ 500
( ) 1,000
( ) 1,500
( ) 2,000
( ) 2,500
( ) 5,000

All medical and indemnity claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you have any questions, or desire one of these deductible amounts to apply to your coverage, please call your Agent for a quote. This offer is valid for thirty days after the effective date of the policy with which this notice is enclosed.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect a medical and indemnity deductible, and your policy is being renewed effective on or after January 1, 1997, you must make your election before the effective date of your policy, otherwise at the next renewal of your policy.

( ) $ 500	**( ) $ 2,500**
( ) $ 1,000	**( ) $ 5,000**
( ) $ 2,000	**( ) Do Not Elect**

( ) $ 2,500 with Aggregate	**( ) Do Not Elect**

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Form WC 66 01 51 A Printed in U.S.A.

Process Date: 10/10/13 **Policy Expiration Date:** 10/01/14

IMPORTANT NOTICE

OKLAHOMA WORKERS' COMPENSATION DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires insurers to offer a medical claim deductible on all Oklahoma Workers Compensation policies. Oklahoma law allows insurers to offer a policy with both medical and indemnity deductible. You may choose a medical deductible only, an indemnity deductible only, or you may choose both a medical and indemnity deductible. You may also choose to reject both.

Five medical deductible options are available. You are not required to select the medical deductible option, but if you choose to exercise this option, you may choose only one deductible amount. Please carefully review the requirements for the medical deductible option outlined below.

Five indemnity deductible options are available. You are not required to select the indemnity deductible option, but if you choose to exercise this option, you may choose only one deductible amount and it must match the medical deductible amount, if you also selected a medical deductible. Please carefully review the requirements for the indemnity deductible option outlined below.

MEDICAL DEDUCTIBLE OPTIONS

The medical claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the medical benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF MEDICAL DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the medical deductible amount to the injured worker or insurer.

If you choose a medical deductible option, the insurer will pay the entire cost of medical bills directly to the provider of the services and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty days of a written demand. If you fail to reimburse the insurer within sixty days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

MEDICAL DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes, I have read the medical deductible information outlined above and want the following medical deductible amount to apply to medical claims under Oklahoma Workers' Compensation Law. I understand that this medical deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

☐ No, I do not want the medical deductible described in this notice.

INDEMNITY DEDUCTIBLE OPTIONS

The indemnity claim deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the indemnity benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually that are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF INDEMNITY DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the indemnity deductible amount to the injured worker or the insurer.

Form 35-4A
Form WC 66 01 55 E Printed in U.S.A.
Process Date: 10/10/13
Policy Expiration Date: 10/01/14

If you choose an indemnity deductible option, the insurer will pay the entire cost of indemnity benefits and then bill you for the deductible amount. **WARNING: You must reimburse the deductible amount to the insurer within sixty (60) days of a written demand. If you fail to reimburse the insurer within sixty (60) days, the insurer may seek to recover the FULL AMOUNT of the claim from you.**

INDEMNITY DEDUCTIBLE ACCEPTANCE/REJECTION

☐ Yes I have read the indemnity deductible information outlined above and want the following indemnity deductible amount to apply to indemnity claims under Oklahoma workers compensation law. I understand that this indemnity deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee. I understand that the indemnity deductible amount chosen must match the medical deductible amount chosen, if I also selected a medical deductible.

☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500

☐ No, I do not want the indemnity deductible described in this notice.

NAMED INSURED _____
ADDRESS _____
TITLE _____
SIGNATURE _____
DATE _____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part. If you have any questions, please call your agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Form 35-4A
Form WC 66 01 55 E Printed in U.S.A.

IMPORTANT NOTICE

KENTUCKY WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Kentucky Workers' Compensation law permits an employer to purchase workers' compensatio n insurance with a deductible. The deductible is for medical and indemnity benefits only.
Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal.

( )	$ 100	( )	$ 1,500
( )	$ 200	( )	$ 2,500
( )	$ 300	( )	$ 5,000
( )	$ 400	( )	$ 7,500
( )	$ 500	( )	$10,000
( )	$ 1,000		

All claims shall be paid by the company, in such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

IMPORTANT NOTICE

NEW YORK WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New York Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 100	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
[ ]	$ 200	0.3%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
[ ]	$ 300	0.4%	0.3%	0.3%	0.3%	0.2%	0.2%	0.1%
[ ]	$ 400	0.5%	0.5%	0.3%	0.3%	0.3%	0.2%	0.2%
[ ]	$ 500	0.6%	0.5%	0.4%	0.4%	0.3%	0.3%	0.3%
[ ]	$1,000	1.1%	1.0%	0.8%	0.7%	0.6%	0.5%	0.5%
[ ]	$1,500	1.6%	1.4%	1.1%	1.0%	0.9%	0.7%	0.6%
[ ]	$2,000	2.1%	1.8%	1.4%	1.3%	1.2%	0.9%	0.8%
[ ]	$2,500	2.4%	2.2%	1.7%	1.5%	1.4%	1.1%	1.0%
[ ]	$5,000	4.4%	3.9%	3.2%	2.8%	2.6%	2.0%	1.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to:
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

ARKANSAS WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Recent changes in Arkansas Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect only one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION

APPLICABLE TO TOTAL LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 1,000	8.3%	6.6%	5.6%	4.7%	3.9%	2.6%	1.9%
[ ]	1,500	10.2%	8.2%	7.0%	5.9%	4.9%	3.3%	2.4%
[ ]	2,000	11.6%	9.5%	8.1%	6.8%	5.7%	4.0%	2.9%
[ ]	2,500	12.8%	10.5%	9.0%	7.6%	6.4%	4.5%	3.3%
[ ]	3,000	13.9%	11.4%	9.8%	8.4%	7.0%	5.0%	3.6%
[ ]	3,500	15.0%	12.3%	10.5%	9.1%	7.7%	5.5%	4.0%
[ ]	4,000	15.9%	13.1%	11.2%	9.7%	8.2%	5.9%	4.3%
[ ]	4,500	16.7%	13.8%	12.0%	10.3%	8.8%	6.3%	4.6%
[ ]	5,000	17.5%	14.5%	12.5%	10.9%	9.2%	6.8%	4.9%

APPLICABLE TO INDEMNITY LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
[ ]	$ 1,000	1.6%	1.3%	1.2%	1.1%	1.0%	0.8%	0.6%
[ ]	1,500	2.2%	1.8%	1.6%	1.5%	1.3%	1.1%	0.8%
[ ]	2,000	2.7%	2.2%	2.0%	1.9%	1.7%	1.4%	1.0%
[ ]	2,500	3.3%	2.7%	2.4%	2.2%	2.0%	1.7%	1.2%
[ ]	3,000	3.7%	3.1%	2.7%	2.6%	2.2%	1.9%	1.3%
[ ]	3,500	4.1%	3.4%	3.1%	2.9%	2.6%	2.1%	1.5%
[ ]	4,000	4.5%	3.7%	3.4%	3.2%	2.7%	2.3%	1.7%
[ ]	4,500	4.9%	4.0%	3.7%	3.5%	3.0%	2.6%	1.9%
[ ]	5,000	5.2%	4.3%	4.0%	3.7%	3.3%	2.7%	2.0%

APPLICABLE TO MEDICAL LOSSES
HAZARD GROUP

		A	B	C	D	E	F	G
☐	$ 1,000	8.1%	6.5%	5.4%	4.5%	3.7%	2.5%	1.8%
☐	1,500	9.7%	7.9%	6.6%	5.6%	4.6%	3.1%	2.2%
☐	2,000	11.0%	8.9%	7.6%	6.4%	5.3%	3.6%	2.6%
☐	2,500	12.1%	9.8%	8.4%	7.1%	5.9%	4.1%	2.9%
☐	3,000	13.0%	10.6%	9.1%	7.7%	6.5%	4.5%	3.3%
☐	3,500	13.7%	11.3%	9.7%	8.2%	6.9%	4.9%	3.5%
☐	4,000	14.4%	12.0%	10.2%	8.7%	7.4%	5.2%	3.8%
☐	4,500	15.1%	12.5%	10.7%	9.1%	7.7%	5.5%	4.0%
☐	5,000	15.7%	13.0%	11.2%	9.6%	8.1%	5.8%	4.2%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return to
Issuing Office:
Address:

IMPORTANT NOTICE

SOUTH CAROLINA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

South Carolina Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$100	0.6%	0.4%	0.4%	0.3%	0.2%	0.2%	0.1%
( )	$200	1.1%	0.8%	0.7%	0.5%	0.5%	0.3%	0.2%
( )	$300	1.6%	1.2%	1.0%	0.8%	0.7%	0.5%	0.4%
( )	$400	2.0%	1.5%	1.3%	1.1%	0.9%	0.6%	0.4%
( )	$500	2.4%	1.8%	1.5%	1.3%	1.1%	0.7%	0.5%
( )	$1,000	3.8%	3.0%	2.5%	2.1%	1.7%	1.2%	1.0%
( )	$1,500	4.8%	3.8%	3.2%	2.7%	2.3%	1.6%	1.3%
( )	$2,000	5.6%	4.5%	3.8%	3.2%	2.7%	2.0%	1.5%
( )	$2,500	6.3%	5.1%	4.3%	3.7%	3.2%	2.3%	1.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

WORKERS' COMPENSATION SELECTION OF DESIGNATED MEDICAL PROVIDER DISCLOSURE STATEMENT

If you select two Designated Medical Providers meeting the following qualifications, a premium credit will be applied to your policy. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

A qualified Designated Medical Provider is a medical provider, who:

1) **Has a knowledge of work injuries;**
2) **Is knowledgeable of fee schedules;**
3) **Is decisive on medical-maximum-improvement determinations;**
4) **Communicates with you, the employer on such issues as case management and wellness programs;**
5) **Is knowledgeable of the employers operations.**

The names of the providers must be posted and well publicized by you, the employer.

** SIGN AND RETURN **

I am aware of the availability of a premium credit of 2.5%, if I select two qualified Designated Medical Providers. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

Insured Signature _____

Policy Number 37 WB BN3284

Issuing Office THE HARTFORD

Issuing Office Address 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

VIRGINIA DRUG FREE WORKPLACE CREDIT

Name of Employer: WALSWORTH PUBLISHING COMPANY, INC.

Policy Number: 37 WB BN3284

This form attests to your agreement to implement and/or continue to monitor the drug free workplace program you have established throughout the policy period. By signing this form, you agree to continue the following activities or notify us of your intent to discontinue such practices.

- Provide notice to employees and job applicants including a written statement containing the policy on employee drug use, type of drug testing that may be required, actions that can be taken if the test result is positive, consequences of refusing to submit to a drug test, and a list of all drugs for which you will test.

- Educate employees and supervisors about the drug free program in place.

- Require discharge or discipline of any employee whose drug test result is confirmed positive as well as follow-up testing; post-accident testing after every on-the-job accident or injury resulting in loss of work time; pre-employment drug testing; random and reasonable suspicion testing of existing employees; discharge or discipline employees for refusal to submit to drug testing; and maintain compliance with the drug free program throughout the year.

You also agree The Hartford has the right to inspect your records and/or workplaces to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Signature by or on behalf of the Insured: _____

Title: _____ Date: _____

Company: _____

SOUTH CAROLINA - APPLICATION FOR DRUG AND ALCOHOL FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: WALSWORTH PUBLISHING COMPANY, INC.
Policy Number: 37 WB BN3284
Date Program Implemented: _____

This form must be completed by you and returned to your carrier with a copy of applicable documentation as proof of compliance before the premium credit of five percent (5%) can be established and processed. *A program must be certified during each year the employer receives credit.* Failure to do so will remove you from eligibility for this credit.

The following are the four (4) minimum requirements necessary for a qualified employer workplace program. Please check the items below that apply.

( ) 1) Substance Abuse Policy Statement:

Any policy must be designed to help employees who need substance abuse assistance while, at the same time, sending a clear message that the abuse of drugs and alcohol is not compatible with employment in that employer's workplace. The policy statement must evidence both the employer's respect for its employees and the employer's need to maintain a safe, productive, substance-abuse-free environment.

( ) 2) Employee Notification:

In order to protect the individual rights of each employee and to begin the employee education process necessary for a well-defined, well-managed workplace drug and alcohol abuse prevention program, each existing employee and each new employee hired after program implementation must be given a clear, concise, readable notice of the program, the program's requirements, the policy statement, and the employer's expectations under the program. Notification should be, and should remain posted in employee common areas. In addition, each existing employee and each new employee must be given, by mail or by in-person delivery, a copy of the notice. Delivery may be accomplished by inclusion of the notice within the employee's paycheck package or any similarly important-to-the-employee correspondence or benefits delivery.

( ) 3) Testing Procedure:

The testing procedure must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer and must provide for a second test to be administered within thirty minutes of the administration of the first test. Positive test results must be provided in writing to the employee within twenty-four hours of the time the employer receives the test results. Each employer must keep records of each test for up to one year.

( ) 4) Test Results Confidentially Protocols:

Test results, information, interviews, reports, statements, and memorandums received by the employer must be considered confidential and may not be used, received, or discovered in civil, criminal, or administrative proceedings. The burden to protect against unauthorized release is placed not only upon the employer and any laboratory, medical review officer, or rehabilitation program or their agents, but also upon the underwriting insurer. Employers, laboratories, medical review officers, insurers, drug or alcohol rehabilitation programs, and employer drug prevention programs, and their agents who receive or have access to information concerning test results shall keep all information confidential. Release of such information under any other circumstance shall be solely pursuant to a written consent form signed voluntarily by the employee tested or his designee unless the release is completed through disclosure by an agency of the State in a civil or administrative proceeding, order of a court of competent jurisdiction, or determination of a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain at a minimum:

(1) the name of the person who is authorized to obtain the information;
(2) the purpose of the disclosure;
(3) the precise information to be disclosed;
(4) the duration of the consent; and
(5) the signature of a person authorizing release of the information.

Information on test results shall not be released for or used or admissible in any criminal proceeding against the employee.

I certify that the above information is accurate and that I may be subject to an additional premium charge if it is determined that there is any misrepresentation of the established drug and alcohol free workplace program criteria. This is a true and factual depiction of my current program.

Employer Name	Date	Officer/Owner Signature*

Application must be signed by an officer or owner

Title

Notary Public's Signature	Date	Exp. of Commission

Form WC 66 02 85 A Printed in U.S.A.
Process Date: 10/10/13

Policy Expiration Date: 10/01/14

WORKERS' COMPENSATION COST CONTAINMENT CERTIFICATION DISCLOSURE STATEMENT

Cost Containment Certification is available from the Colorado Workers' Compensation Cost Containment Board. If you obtain certification, your policy will be subject to a premium credit which will be shown separately on your policy.

PLEASE CHECK ONE (1) OF THE FOLLOWING BOXES BASED UPON YOUR BUSINESS ENTITY QUALIFICATION:

☐ I am aware if my business **does qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business has implemented a certified workers' compensation risk management program, my policy is subject to a 5% premium credit if the loss experience has improved since the last renewal date of workers' compensation insurance. This 5% premium credit is in addition to any schedule rating for which I may qualify.

or,

☐ I am aware if my business **does not qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business entity has implemented a certified workers' compensation risk management program, my policy is subject to the following premium credit:

Premium Dividend	Dividend Criteria
10%	If my business has been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If my business had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If my business had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
4%	If my business had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
2%	If my business had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If my business had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

PLEASE SIGN AND RETURN

Insured Signature

Policy Number 37 WB BN3284

Issuing Office **THE HARTFORD**
Issuing Office Address **8711 UNIVERSITY EAST DRIVE**
CHARLOTTE NC **28213**

Privacy Policy and Practices of The Hartford Financial Services Group, Inc. and its Affiliates
(herein called "we, our, and us")

This Privacy Policy applies to our United States Operations

We value your trust. We are committed to the responsible:
a) management;
b) use; and
c) protection;
of **Personal Information**.

This notice describes how we collect, disclose, and protect **Personal Information**.

We collect **Personal Information** to:
a) service your **Transactions** with us; and
b) support our business functions.

We may obtain **Personal Information** from:
a) **You**;
b) your **Transactions** with us; and
c) third parties such as a consumer-reporting agency.

Based on the type of product or service **You** apply for or get from us, **Personal Information** such as:
a) your name;
b) your address;
c) your income;
d) your payment; or
e) your credit history;
may be gathered from sources such as applications, **Transactions**, and consumer reports.

To serve **You** and service our business, we may share certain **Personal Information**. We will share **Personal Information**, only as allowed by law, with affiliates such as:
a) our insurance companies;
b) our employee agents;
c) our brokerage firms; and
d) our administrators.

As allowed by law, we may share **Personal Financial Information** with our affiliates to:
a) market our products; or
b) market our services;
to **You** without providing **You** with an option to prevent these disclosures.

We may also share **Personal Information**, only as allowed by law, with unaffiliated third parties including:
a) independent agents;
b) brokerage firms;
c) insurance companies;
d) administrators; and
e) service providers;
who help us serve **You** and service our business.

When allowed by law, we may share certain **Personal Financial Information** with other unaffiliated third parties who assist us by performing services or functions such as:
a) taking surveys;
b) marketing our products or services; or
c) offering financial products or services under a joint agreement between us and one or more financial institutions.

We will not sell or share your **Personal Financial Information** with anyone for purposes unrelated to our business functions without offering **You** the opportunity to:
a) "opt-out;" or
b) "opt-in;"
as required by law.

We only disclose **Personal Health Information** with:
a) your proper written authorization; or
b) as otherwise allowed or required by law.

Our employees have access to **Personal Information** in the course of doing their jobs, such as:
a) underwriting policies;
b) paying claims;
c) developing new products; or
d) advising customers of our products and services.

We use manual and electronic security procedures to maintain:
a) the confidentiality; and
b) the integrity of;
Personal Information that we have. We use these procedures to guard against unauthorized access.

Some techniques we use to protect **Personal Information** include:

a) secured files;
b) user authentication;
c) encryption;
d) firewall technology; and
e) the use of detection software.

We are responsible for and must:

a) identify information to be protected;
b) provide an adequate level of protection for that data;
c) grant access to protected data only to those people who must use it in the performance of their job-related duties.

Employees who violate our Privacy Policy will be subject to discipline, which may include ending their employment with us.

At the start of our business relationship, we will give **You** a copy of our current Privacy Policy.

We will also give **You** a copy of our current Privacy Policy once a year if **You** maintain a continuing business relationship with us.

We will continue to follow our Privacy Policy regarding **Personal Information** even when a business relationship no longer exists between us.

As used in this Privacy Notice:

Application means your request for our product or service.

Personal Financial Information means financial information such as:

a) credit history;
b) income;
c) financial benefits; or
d) policy or claim information.

Personal Health Information means health information such as:

a) your medical records; or
b) information about your illness, disability or injury.

Personal Information means information that identifies **You** personally and is not otherwise available to the public. It includes:

a) **Personal Financial Information**; and
b) **Personal Health Information**.

Transaction means your business dealings with us, such as:

a) your **Application**;
b) your request for us to pay a claim; and
c) your request for us to take an action on your account.

You means an individual who has given us **Personal Information** in conjunction with:

a) asking about;
b) applying for; or
c) obtaining;

a financial product or service from us if the product or service is used mainly for personal, family, or household purposes.

This Privacy Policy is being provided on behalf of the following affiliates of The Hartford Financial Services Group, Inc.:

1stAGChoice, Inc.; Access CoverageCorp, Inc.; Access CoverageCorp Technologies, Inc.; American Maturity Life Insurance Company; Archway 60 R, LLC; Business Management Group, Inc.; Catalyst360, LLC; Champlain Life Reinsurance Company; DMS R, LLC; Eloy R, LLC; Ersatz Corporation; First State Insurance Company; Hartford Accident and Indemnity Company; Hartford Administrative Services Company; Hartford Casualty General Agency, Inc.; Hartford Casualty Insurance Company; Hartford-Comprehensive Employee Benefit Service Company; Hartford Equity Sales Company, Inc.; Hartford Fire General Agency, Inc.; Hartford Fire Insurance Company; Hartford Funds Management Company, LLC; Hartford Funds Management Group, Inc.; Hartford HLS Series Fund II, Inc.; Hartford Insurance Company of Illinois; Hartford Insurance Company of the Midwest; Hartford Insurance Company of the Southeast; Hartford Integrated Technologies, Inc.; Hartford International Life Reassurance Corporation; Hartford Investment Financial Services, LLC; Hartford Investment Management Company; Hartford Life and Accident Insurance Company; Hartford Life and Annuity Insurance Company; Hartford Life Insurance Company; Hartford Life Private Placement, LLC; Hartford Lloyd's Corporation; Hartford Lloyd's Insurance Company; Hartford Mezzanine Investors I, LLC; Hartford Residual Market, L.C.C.; Hartford Retirement Services, LLC; Hartford Securities Distribution Company, Inc.; Hartford Series Fund, Inc.; Hartford Specialty Insurance Services of Texas, LLC; Hartford Strategic Investments, LLC; Hartford Underwriters Insurance Company; Hartford Technology Services Company, L.L.C.; Hartford of Texas General Agency, Inc.; Hartford Underwriters General Agency, Inc.; HARTRE Company, L.C.C.; HL Investment Advisors, LLC; HLA LLC; Horizon Management Group, LLC; HRA Brokerage Services, Inc.; Lanidex Class B, LLC; M-CAP Insurance Agency, LLC; New England Insurance Company; New England Reinsurance Corporation; Nutmeg Insurance Agency, Inc.; Nutmeg Insurance Company; Pacific Insurance Company, Limited; Planco, LLC; Property and Casualty Insurance Company of Hartford; Revere R, LLC; RVR R, LLC; Sentinel Insurance Company, Ltd.; Sunstone R, LLC; Symphony R, LLC; The Evergreen Group Incorporated; The Hartford Alternative Strategies Fund; The Hartford Mutual Funds, Inc.; The Hartford Mutual Funds II, Inc.; Trumbull Flood Management, L.L.C.; Trumbull Insurance Company; Twin City Fire Insurance Company; White River Life Reinsurance Company.

IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized $2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject this deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone No.: ( ) _____
C. Address: _____

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

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.
THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature	Date	Expiration of Commission

Reporting a Work-Related Injury is Time Sensitive!

Call The Hartford's LossConnect immediately to report a claim.
1-800-327-3636
Available 24 hours a day, 365 days a year.

The Benefits of Timely Loss Reporting:

Research has shown that faster loss reporting significantly affects loss costs. The sooner we are notified, the sooner we can investigate the accident and coordinate with you, the injured employee, and the medical team to ensure the fastest possible return to health and work.

The Effect of Timely Reporting on Controlling the Cost of Your Loss:

Average Loss for Closed Claims (Accident Years 2002-2005)	
Report Lag in Days	**Percent Change in Loss Costs Compared to First Week Report**
Incident Day	-6%
Week 1	0%
Week 2	13%
Week 3 or 4	16%
1 Month or Later	24%

Statutory requirements also necessitate the prompt initial reporting of the accident causing injury or death. Failure to comply may result in a fineable offense by the State.

Information You'll Need

Company Information
- Account Number
- Location Code (if applicable)
- Parent Company (or program name)
- Policy Number

Worker Information
- Name, DOB, Address, Phone
- Social Security Number
- Age, Gender
- Marital Status, Number of Dependants
- Hire Date, Years in Current Position
- Wage Information

Incident Information
- Type of injury (burn, cut, etc.)?
- Exact body part injured?
- What caused the accident?
- Any reason to question the injury?
- Any witnesses?
- Address where injury occurred?
- Where was the injured employee treated? (Provide name, address, phone of medical provider.)
- When was the accident reported to you and by whom (date, time)?

Network Providers
A listing of more than 400,000 network providers qualified to treat work-related injuries is available online at www.talispoint.com/hartext or by calling our Network Referral Unit at 1-800-327-3636 (select 4 at the prompt). Since network referrals are often impacted by state specific rules, please call to learn how to maximize our network capabilities on behalf of your employees.

Form WC 66 03 84 Printed in U.S.A.

Reporting a Work-Related Injury is Time Sensitive!

Call The Hartford's LossConnect immediately to report a claim.
1-800-327-3636
Available 24 hours a day, 365 days a year.

The Benefits of Timely Loss Reporting:

Research has shown that faster loss reporting significantly affects loss costs. The sooner we are notified, the sooner we can investigate the accident and coordinate with you, the injured employee, and the medical team to ensure the fastest possible return to health and work.

The Effect of Timely Reporting on Controlling the Cost of Your Loss:

Average Loss for Closed Claims (Accident Years 2002-2005)	
Report Lag in Days	**Percent Change in Loss Costs Compared to First Week Report**
Incident Day	-6%
Week 1	0%
Week 2	13%
Week 3 or 4	16%
1 Month or Later	24%

***Statutory requirements also necessitate the prompt initial reporting of the accident causing injury or death.**

Information You'll Need

Company Information

- Account Number
- Location Code (if applicable)
- Parent Company (or program name)
- Policy Number

Worker Information

- Name, DOB, Address, Phone
- Social Security Number
- Age, Gender
- Marital Status, Number of Dependants
- Hire Date, Years in Current Position
- Wage Information

Incident Information

- Type of injury (burn, cut, etc.)?
- Exact body part injured?
- What caused the accident?
- Any reason to question the injury?
- Any witnesses?
- Address where injury occurred?
- Where was the injured employee treated? (Provide name, address, phone of medical provider.)
- When was the accident reported to you and by whom (date, time)?

Network Providers

A listing of more than 400,000 network providers qualified to treat work-related injuries is available online at www.talispoint.com/hartext or by calling our Network Referral Unit at 1-800-327-3636 (select 4 at the prompt). Since network referrals are often impacted by state specific rules, please call to learn how to maximize our network capabilities on behalf of your employees.

Employers must report the claim to their insurers no later than 5 days after notice or knowledge of any claim or accident that may result in a compensable injury (656.262(3)(a)). The employer's knowledge date is the earliest of the date the employer first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.

WEST VIRGINIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

West Virginia Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	**$100**	1.7%	1.2%	1.0%	0.8%	0.6%	0.4%	0.3%
( )	**$200**	2.9%	2.2%	1.8%	1.5%	1.1%	0.8%	0.6%
( )	**$300**	3.7%	2.8%	2.3%	1.9%	1.6%	1.1%	0.8%
( )	**$400**	4.3%	3.4%	2.8%	2.3%	1.9%	1.3%	1.0%
( )	**$500**	4.9%	3.8%	3.2%	2.7%	2.2%	1.5%	1.1%
( )	**$1,000**	7.0%	5.5%	4.8%	3.9%	3.3%	2.3%	1.8%
( )	**$1,500**	8.6%	6.9%	6.0%	5.0%	4.2%	3.0%	2.3%
( )	**$2,000**	10.0%	8.1%	7.0%	6.0%	5.0%	3.7%	2.9%
( )	**$2,500**	11.2%	9.1%	7.9%	6.8%	5.7%	4.3%	3.4%
( )	**$5,000**	16.3%	13.4%	11.9%	10.4%	8.9%	6.9%	5.4%
( )	**$7,500**	20.0%	16.8%	15.1%	13.3%	11.5%	9.1%	7.2%
( )	**$10,000**	23.1%	19.7%	17.8%	15.8%	13.7%	11.0%	8.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number		
37 WB BN3284		
Employer Name	**Date**	**Signature and Title**
WALSWORTH PUBLISHING COMPANY, INC.		
Agent Name	**Date**	**Signature**
LOCKTON COMPANIES LLC		

Return this form to:
Issuing Office: THE HARTFORD
Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

Form WC 66 03 88 D Printed in U.S.A.
Process Date: 10/10/13
Policy Expiration Date: 10/01/14

IMPORTANT NOTICE

ALABAMA WORKERS' COMPENSATION INSURANCE MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Alabama Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.9%	0.6%	0.5%	0.4%	0.4%	0.3%	0.2%
( )	$ 200	1.7%	1.3%	1.0%	0.8%	0.7%	0.4%	0.3%
( )	$ 300	2.4%	1.8%	1.5%	1.3%	1.0%	0.7%	0.5%
( )	$ 400	3.1%	2.3%	1.9%	1.6%	1.3%	0.9%	0.6%
( )	$ 500	3.6%	2.8%	2.3%	1.9%	1.6%	1.1%	0.8%
( )	$ 1,000	5.6%	4.4%	3.8%	3.1%	2.6%	1.8%	1.3%
( )	$ 1,500	6.9%	5.5%	4.6%	3.9%	3.3%	2.3%	1.7%
( )	$ 2,000	7.8%	6.3%	5.4%	4.5%	3.8%	2.7%	2.0%
( )	$ 2,500	8.6%	7.0%	6.0%	5.1%	4.3%	3.0%	2.3%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 37 WB BN3284		
Employer Name WALSWORTH PUBLISHING COMPANY, INC.	**Date**	**Signature and Title**
Agent Name LOCKTON COMPANIES LLC	**Date**	**Signature**

Return this form to

Issuing Office: THE HARTFORD

Address: 8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213

NOTICE TO MICHIGAN POLICYHOLDERS

This policy or bond is exempt from the filing requirements of section 2236, 2401 and 2601 of the insurance code of 1956, 1956 PA 218, MCL 500.2236.

NEVADA NOTICE TO POLICYHOLDERS

In accordance with Chapter 680B of the Nevada Revised Statutes, each renewal must include information on taxes, fees, and assessments included in the premium you are required to pay.

A portion of the premium for this policy is attributable to the general premium tax we are required to pay to the State of Nevada pursuant to Section 680B.027 of the Nevada Revised Statutes.

A portion of the premium for this policy is also attributable to annual fees or assessments we are required to pay to the State of Nevada.

IMPORTANT NOTICE

Minnesota State Workmen's Compensation Law requires that compensation payments to injured workers begin within fourteen days after the first day of disability. If the Industrial Commission should find that a delay was due to your failure to report a claim to the company they would insist on the **penalty being paid by you and would not permit your insurance company to reimburse you.**

To avoid any possibility of a substantial penalty, report all accidents and claims to our claim representative immediately. If you are unable to contact our claim representative, notify your agent and ask him to see that the claim report is made out and filed without delay.

Form WC 66 00 01 Printed in U.S.A.

IMPORTANT WORKERS' COMPENSATION NOTICE
MICHIGAN BUILDING WRECKING PLAN

Effective January 1, 1976 you are required to report to this company all operations involving demolition work in the State of Michigan prior to their commencement.

Failure to report operations of this nature will result in a penalty of 200% of the standard charge for the operation under the Michigan Building Wrecking Plan.

Note that 'Demolition' refers to the razing of a building, chimney or steeple or the removal of a floor, exterior wall or roof.

IMPORTANT NOTICE

Michigan State Workmen's Compensation Law requires that compensation payments to injured workers begin within fourteen days after the accident is reported to the employer. If the Department of Labor should find that a delay was due to your failure to report a claim to the company they would insist on the penalty being paid by you and would not permit your insurance company to reimburse you.

To avoid any possibility of a substantial penalty, report all accidents and claims to our claim representative immediately. If you are unable to contact our claim representative, notify your agent and ask him to see that the claim report is made out and filed without delay.

TAX AND ASSESSMENT CHARGE
KENTUCKY

The Kentucky Insurance Department does not consider taxes and assessments a part of Workers' Compensation Insurance Rates. The monies charged for taxes and assessments are not included as premium under the policy.

The company merely acts as a tax collector with respect to taxes and assessments and is required under the Workers' Compensation Law to collect and remit the taxes and assessments to the Kentucky Commissioner of Revenue.

For new and renewal policies effective January 1, 2012 and later, the tax and assessment rate is 6.28%. For employees engaged in the severance and processing of coal, the tax and assessment rate is 0.0%.

CALIFORNIA NOTICE

CALIFORNIA LABOR CODE 3551 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS CODE, EXCEPT EMPLOYERS OF EMPLOYEES DEFINED IN SUBDIVISION (d) OF SECTION 3351, SHALL GIVE EVERY NEW EMPLOYEE, EITHER AT THE TIME OF HIRE, OR BY THE END OF THE FIRST PAY PERIOD, WRITTEN NOTICE OF THE INFORMATION CONTAINED IN SECTION 3550.

CALIFORNIA LABOR CODE 3550 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS DIVISION SHALL POST AND KEEP POSTED IN A CONSPICUOUS LOCATION FREQUENTED BY EMPLOYEES, AND WHERE THE NOTICE MAY BE EASILY READ BY EMPLOYEES DURING THE HOURS OF THE WORKDAY, A NOTICE WHICH SHALL STATE THE NAME OF THE CURRENT COMPENSATION INSURANCE CARRIER OF THE EMPLOYER, OR WHEN SUCH IS THE FACT, THAT THE EMPLOYER IS SELF-INSURED, AND WHO IS RESPONSIBLE FOR CLAIMS ADJUSTMENT.

NOTICE TO POLICYHOLDER

Rates and Premiums

Your workers' compensation policy contains rates and classifications applicable to employees engaged in your type of business. If you have any questions regarding the rates or classifications used on your policy, you may contact your Agent or:

THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

If you feel your concerns have not been resolved, you may submit a written request (to the address shown above) for information pertinent to the rates or classifications used on your policy.

The method used in determination of the rates and premium will be reviewed. If you are dissatisfied with the review, you may appeal the results to:

Commissioner of Insurance
Michigan Insurance Bureau
Department of Licensing and Regulation
P.O. Box 30220
Lansing, Michigan 48909

Payroll Audits

Your policy provides for one or more payroll audits. If you have reason to believe that you have experienced a change in payroll expenditures of 20% or more, you may submit a written request to the company at the address shown above indicating a 20% or greater change has occurred and the reason for that belief. A payroll audit will be conducted within 120 days of receipt of your written request. You are entitled to only one requested payroll audit per calendar year.

Reserves or Redemption

Redemption of claims and establishment of reserves to pay claims are common practices. If you have reason to believe that the premiums charged are excessive as a result of unreasonable reserves or unreasonable redemption of a claim, you may submit a written request for a meeting with a management representative to the company address shown above. If the meeting does not resolve the dispute, you are entitled to a determination of the dispute by the Insurance Commissioner. To obtain reserve and redemption information pertinent to the premiums charged on your policy, you may submit a written request to the company address shown above and the information will be provided within 30 days of receipt of your request.

IMPORTANT NOTICE

Please read carefully and retain for future reference.

To Workmen's Compensation Policyholders - State of Connecticut

1. Under the Workmen's Compensation Law you are required to make an immediate report in duplicate (Employer's Report of Injury), of all injuries occurring in the course of employment. An injury to be reported must:
   A. Cause loss of time from regular work for one day or more, or
   B. Require treatment beyond first aid, i.e. outside treatment by a physician.
   C. Serious or fatal injuries should be reported to the carrier at once, by telephone.

   Failure of employer to make a prompt report, or to conform to any of the provisions of the Compensation Law may subject the employer to a $250 fine for each such failure. **This fine is assessed directly against** the employer, (Sec. 31-288).

2. Under the Workmen's Compensation Law, the insurance carrier on behalf of the employer must:
   A. Pay any compensation due, **within ten days** (Sec. 31-303)
   B. Contest the claim on or before the 20th day following the date of the employer's knowledge of the injury, (Sec. 31-297).

3. To avoid delay in paying benefits, the Employer's Report of Injury must accurately state the employee's earnings. To avoid overpayment, immediately notify the carrier when the employee returns to work.

   The law specifies that notice to employer is notice to carrier. We, as the carrier, cannot act quickly and efficiently in your interest, unless prompt notice of an injury is received. Your cooperation is earnestly solicited.

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We're protected by

WORKERS' COMPENSATION

Follow safety rules and ***you'll*** be protected from injury. But if you ***are*** injured at work, you're protected by benefits.

PREVENT THE ABUSE OF WORKERS' COMPENSATION CLAIMS

We Help Employers Fight Fraud

If you suspect a claim is fraudulent, or that it abuses the system, work with your insurance carrier to prepare evidence of the alleged fraud. Then Report the case to:

Workers' Compensation Fraud Unit
201 E. Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901

For quick help, call the Fraud Hotline: (608) 261-8486

What We Can Do to Help

The Workers' Compensation Division is authorized by Wisconsin Statute 102.125 to work with employers and insurers to report, investigate, and prosecute allegations of Workers' Compensation fraud. Here's what we do:

- Work with you and your insurance carrier to determine if there is enough evidence to take the case to court.
- Refer the case to the local District Attorney's Office for prosecution if there is sufficient evidence of fraud. Cooperation from the Justice Department and District Attorneys has been excellent. They will prosecute!

PROVE IT!

Conviction of a fraudulent claim requires proof beyond a reasonable doubt of an intentional misrepresentation to secure benefits. Only the best-documented cases succeed.

Prevention Is the Best Defense

A well-designed loss control program and the serious threat of legal action are very effective deterrents to abusive claims.

Fraud Prevention Tips

1. Develop a first-class safety program. Claims are less likely to mushroom if injuries are prevented and employees feel that management is genuinely concerned about their safety. You can do that by establishing and practicing clear and comprehensive safety policies.
2. Establish strong accident investigation procedures. Injured employees and witnesses should be interviewed in person about the accident as soon as possible. Document all statements. Get a signed statement from the claimant.
3. Send the Supervisor with the injured worker to the medical provider. Show concern for getting first-class medical evaluations and treatments.
4. Establish procedures for a clear understanding of essential information. Make sure the treating physician understands the nature of the job. Make sure the supervisor understands return-to-work limitations.
5. Make sure employees understand that false claims can be punished by termination and criminal prosecution.

- **You don't need a lawyer to get benefits**
- **You won't get in trouble for reporting an injury or making a truthful claim.**

Report injuries to your supervisor immediately.

- **Your supervisor will help you start your claim.**
- **Don't make a Workers' Compensation claim unless it's legitimate. You risk jail, a fine or job loss.**

Call the Fraud Hotline if you know about a false claim, (608) 261-8486. Or you can reach the Fraud Unit on the World Wide Web at http://www.dwd.state.wi.us/wc. Save everyone the added insurance costs and a possible reduction in wage increases. Fraud hurts us all.

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POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us

(1) General questions regarding your policy should be directed to your Hartford Agent.

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

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

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

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

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP) and the *California Workers' Compensation Experience Rating Plan—1995* (ERP). Contact information for the WCIRB is: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. You may also contact WCIRB Customer Service at 1-888-229-2472, by fax at 415-778-7272, or via the Internet at the WCIRB's website: http://www.wcirbonline.org. The regulations contained in the USRP and the ERP are available for public viewing through the WCIRB's website.

(2) **Policyholder Information.** Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Custodian of Records. The Custodian of Records can be reached by telephone at 415-777-0777 and by fax at 415-778-7272.

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

II. Dispute Process

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

A. Our Dispute Resolution Process.

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:
SEE ATTACHED ENDORSEMENT
One Pointe Drive, Suite 200, Brea, CA 92821; Telephone (714) 674-1200; Fax (714) 674-1477.

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

B. Disputing the Actions of the WCIRB. If you have been aggrieved by any decision, action, or omission to act of the WCIRB, you may request, in writing, that the WCIRB reconsider its decision, action, or omission to act. You may also request, in writing, that the WCIRB review the manner in which its rating system has been applied in connection with the insurance afforded or offered you. For requests related to classification disputes, the reporting of experience, or coverage issues, your initial request for review must be received by the WCIRB within 12 months after the expiration date of the policy to which the request for review pertains, except if the request involves the application of the Revision of Losses rule. For requests related to your experience modification, your initial request for review must be received by the WCIRB within 6 months after the issuance, or 12 months after the expiration date, of the experience modification to which the request for review pertains, whichever is later, except if the request for review involves the application of the Revision of Losses rule. If the request involves the Revision of Losses rule, the time to state your appeal may be longer. (See Section VI, Rule 14 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. Customer Service can be reached by telephone at 1-888-229-2472, and by fax at 415-778-7272

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether or not your written request will be reviewed. If the WCIRB agrees to review your request, it must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If the WCIRB declines to review your request, if you are dissatisfied with the decision upon review, or if the WCIRB fails to grant or reject your request or issue a decision upon review, you may appeal to the insurance commissioner as described in paragraph II.C., below. Written Complaints and Requests for Action should be forwarded to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Complaints and Reconsiderations. The WCIRB's telephone number is 1-888-229-2472, and the fax number is 415-371-5204.

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

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

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

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

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the insurance commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Policyholder Ombudsman. The policyholder ombudsman can be reached by telephone at 415-778-7159 and by fax at 415-371-5288.

B. California Department of Insurance - Information and Assistance. Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 1-800-927-HELP (4357) or http://www.insurance.ca.gov. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

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

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

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

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.

2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.

3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per $100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.

4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.

5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.

6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.

7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE
NOTICE OF NONRENEWAL

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

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

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

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

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

4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

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

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

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

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

POLICYHOLDER NOTICE

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

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

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

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

Form PN 04 99 04 Printed in U.S.A.

POLICYHOLDER NOTICE

PAYROLL RECORD REQUIREMENTS FOR DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

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

Your policy includes one or more dual wage construction or erection classifications. The assignment of a high wage classification to any non-salaried employee is contingent on verifying that employee's hourly wage by reconciling the total number of hours the employee actually worked during the policy period against the employee's time cards or time sheets that document the operations performed, the daily start and stop times and the total hours worked each day for that employee.

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

The payroll earned by any non-salaried employees for whom we are unable to verify the total number of hours worked will be assigned to the low wage classification that describes the operation performed.

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

Form PN 04 99 06 Printed in U.S.A.

WORKERS COMPENSATION
PARTICIPATING PROGRAM SP-O

Your workers' compensation policy is being written under participating program SP-O.

Dividends under this SP-O program:

1) are contingent upon a sufficient underwriting profit being generated on the total of all policies issued under the program, countrywide, rather than on any individual policies;

2) are only payable on policies issued in states where results have been sufficiently profitable; and

3) cannot be guaranteed and are only payable at the discretion of the Board of Directors of the Company.

Based upon the performance history of the SP-O program, it is unlikely that a dividend will be paid under this program for this policy period.

IMPORTANT NOTICE

Mississippi State Workers' Compensation Law requires that reports of injuries be made to the Mississippi Workers' Compensation Commission within ten (10) days from the first day of lost time from work. If the Workers' Compensation Commission finds that a delay was caused by your failure or refusal to file the report of injury, a penalty of $100 will be assessed to you.

To avoid any possible penalties, report all accidents and claims as soon as you become aware of them. The original report should be sent to: State of Mississippi, Workers' Compensation Commission, P.O. Box 5300, Jackson, Mississippi 39216. Two copies of the report of injury should be sent to the nearest claim office of The Hartford.

An Introduction to Workers Compensation: Background for Oregon Employers

Introduction
In accordance with the intent of the Oregon law, this booklet was prepared for voluntary distribution to Oregon employers by the insurance industry. In it, you will find answers to basic questions about workers compensation insurance.

National Council on Compensation Insurance (NCCI)
The National Council on Compensation Insurance is a voluntary, non-profit, statistical, research and ratemaking organization licensed under Oregon Revised Statutes 737.350. Supported by the insurance industry, NCCI's primary functions are the preparation and administration of rates, rating plans, and systems for workers compensation insurance. In Oregon, NCCI prepares a schedule of rates for insureds in the assigned risk plan, subject to insurance department approval, and acts in an advisory capacity for insurers writing the remainder of the business in the state.

As the rating organization, it is NCCI's obligation to collect payroll and loss information, by individual classification, for each workers compensation insurance policy in the state of Oregon. In addition, the rating organization will perform inspections at employers' premises to determine the proper classifications, perform test audits, promulgate experience rating modifications, and administer the Workers Compensation Insurance Plan (WCIP) for those employers unable to obtain coverage voluntarily.

Workers Compensation Rates
NCCI uses the collected payroll and loss data to actuarially determine that portion of each individual classification rate necessary to pay the losses. This amount is called the pure premium. Oregon insurers may use the pure premiums determined by NCCI, or may derive their own pure premium when preparing their rates. Each carrier applies its own "factor" to provide for the additional costs of taxes, licenses, fees, acquisition and field supervision, and other company expenses. This "factored" rate is the amount charged per $100 of payroll.

Classifications
There are approximately 500 different workers compensation classifications, each of which individually describes a particular occupation. Generally, each employer will be entitled to the ONE basic classification which most accurately describes its operations. In addition, when that one basic classification does not specifically include one of the "Standard Exception" classifications (Clerical, Outside Salespersons, or Drivers), each employer may also be entitled to three additional classifications: Code 7380 - Drivers, Chauffeurs & Helpers; Code 8742 - Salespersons, Collectors or Messengers - Outside; and Code 8810 - Clerical Office Employees. Your insurance carrier will advise you of the classifications applicable to your operations.

However, when an employer is engaged in Construction, Erection, Stevedoring, Aircraft Operations (Industrial Aid), or Trucking as a secondary business, additional classifications may be assigned. Again, your carrier will counsel you on the classifications applicable to your operations.

Division of Individual Employee's Payroll
When any employee performs different duties which, if performed by a different worker, would qualify for a different classification assignment, you may divide that person's payroll between two or more classifications, PROVIDED separate verifiable payroll records are adequately maintained. When verifiable payroll records are not maintained, that individual's payroll must be assigned to the highest-rated classification for any of the duties performed.

Verifiable Records
Payroll records of an employee are verifiable if they have the following characteristics: (a) The records must establish a time basis, and the time basis must be hourly or a part thereof, daily or part thereof, weekly or part thereof, monthly or part thereof or yearly or part thereof; (b) For each salaried employee, the records must also include time records in which the salary is converted to an hourly, daily, weekly, monthly or yearly rate and then multiplied by the time spent by the employee in each classification exposure; (c) The records must include a description of duties performed by the employee, to enable the insurer to determine correct classification assignment. Records requiring additional explanation or interpretation are not considered to be verifiable; and (d) The records must be supported by original entries from other records, including but not limited to time cards, calendars, planners or daily logs prepared by the employee or the employee's direct supervisor or manager. Estimated ratios or percentages of time spent performing the different duties are not acceptable for verification. Verifiable records must be summarized in the employer's accounting records.

Remuneration - Payroll
'Payroll' means the TOTAL remuneration paid or payable by the employer for the services of the employees covered by the policy. Payroll INCLUDES commissions, anticipated bonuses, straight hourly wages for all hours worked, holiday pay, sick pay, piecework pay, tool allowances, value of living quarters provided by the employer, value of meals provided, value of store certificates or merchandise

provided, and credits or any other substitute for money received by employees. Payroll does NOT INCLUDE profit-sharing amounts, unanticipated bonuses, vacation pay, tips or other gratuities received by employees from others, payments by the employer to group insurance or group pension plans, value of special rewards for individual invention or discovery, the value of a company-provided vehicle which is used in the employer's business, or dismissal or severance payments except for the pay earned for the time worked. It also excludes payments from a program to reward workers for safe working practices.

Subcontractors
When you subcontract a portion (or all) of your work to others and retain the right to exercise any direction and control (regardless of whether that right is exercised), you will be expected to pay the premiums for that subcontracted payroll UNLESS the subcontractor has its own workers compensation insurance coverage. In order to avoid the payment of premium for your subcontractors, you should obtain a CERTIFICATE OF INSURANCE from each subcontractor. At the time of audit, your insurance carrier will ask for any certificates of insurance and will exclude the subcontractor's payroll when the certificate is available.

Experience Rating
When any employer's initial policy develops an annual premium in excess of $5,000, the employer will qualify for experience rating at the beginning of the THIRD year and annually thereafter. When the employer develops premium in excess of $2,500 (but less than $5,000), they will qualify for an experience rating modification at the beginning of the FOURTH year. These qualifying premium amounts are subject to change.

Essentially, the Experience Rating Program will use your company's payroll, by individual classification, to determine the AVERAGE amount of losses expected to emerge from that payroll. It will then compare those EXPECTED LOSSES to the ACTUAL LOSSES which were paid and/or reserved for any injuries occurring during the period covered by the data used in the annual experience rating process. When your company has BETTER than average experience, the experience modification will result in a CREDIT (reduction in your final premium), but if your experience is WORSE than average, a DEBIT (surcharge) will apply.

Merit Rating
When an employer is too small to qualify for experience rating, a MERIT RATING program will apply. In general, this program will: a) reduce your final premium if there were no payments for "lost-time" injuries during the most recent year for which data has been compiled; b) will not affect your premium when there was only ONE lost-time injury; and c) will surcharge your premium when there are two or more lost-time injuries. Oregon law provides that, with the approval of regulatory authorities, insurance carriers may use their own customized merit rating plan. Maximum credits or surcharges are 10 percent. Check with your insurance carrier or agent for specific information about merit rating plans in effect in Oregon.

Federal Coverages
While most employees will be subject to only the Oregon Workers Compensation Act, others MAY be subject to the Admiralty Act (for masters or members of a vessel), to the Federal Employers Liability Act (railroads engaged in interstate commerce), or the Longshore and Harborworkers Compensation Act (for stevedoring operations, building or repairing of vessels, new construction work in connection with marinas, etc.). However, the determination of exposures under any of the Federal Acts is a legal question which should be discussed with your insurance carrier or agent.

Final Premium
When you obtain a policy from your insurance carrier, the premium will be ESTIMATED from the description of work and payroll information supplied by you. Your insurance carrier may either make interim audits or audit your account when your policy has expired. At that time, your final premium will be based upon the ACTUAL payrolls.

Oregon Classification and Rating Committee
A Committee, composed of members well-versed in workers compensation insurance matters, meets periodically to hear the grievances of employers who feel they have been treated improperly in the assignment of classifications, payroll assignments, or experience ratings. (Since the "rate" is an actuarial product which has been reviewed by the Insurance Department prior to approval for use, the appeal may NOT be based upon the rate for an individual classification.) Should you feel you have been aggrieved, you may direct your specific allegations to NCCI - Northwestern Service Office, One S.W. Columbia (Suite 850), Portland, OR 97258 or contact your carrier for further information.

Conclusion
The above information has been designed to provide you with a broad overview of the Oregon Workers Compensation Insurance system. Should you have further questions, please contact your carrier or NCCI- Northwestern Service Office at the address indicated above.

N O T I C E

The Information Page of your Workers Compensation and Employers Liability Insurance Policy contains line items for (1) a Second Injury Fund Surcharge and (2) an Uninsured Employer's Fund Surcharge. Each surcharge amount represents a percentage of your total estimated standard premium and will be subject to adjustment when the final audited standard premium is determined. Explanations of these surcharges are provided below.

SECOND INJURY FUND

The New Jersey Workers Compensation Law established the Second Injury Fund to provide benefits to workers who become permanently and totally disabled as a result of work-related injury or occupational disease when that worker had been previously partially disabled. The Law also requires that the Fund provide annual adjustments to certain persons permanently and totally disabled and to certain dependents of deceased workers.

Through 1988, the Second Injury Fund was financed by an annual assessment upon insurance carriers. Such assessment was included in your standard premium via the manual premium rate(s) shown in your policy Information Page.

Effective January 1, 1989, an amendment to the Law requires that the present financing be replaced by a direct surcharge shown as a separate "Second Injury Fund Surcharge" line on your policy Information Page. It will no longer be included in the manual premium rate. This new system will discourage other states from imposing retaliatory taxes on New Jersey based insurance companies and ultimately aid cost containment efforts.

UNINSURED EMPLOYERS FUND

The New Jersey Workers Compensation Law requires every employer to provide workers compensation coverage through purchase of a workers compensation and employers liability insurance policy. Failure to provide such coverage results in a fine and/or criminal action by the Department of Labor as well as continued liability for benefit payments to an injured worker.

The Uninsured Employers Fund was established by Law to provide benefits to an injured worker when the employer has failed to comply with the insurance provisions of the Law and is unable to provide the required benefits. Through 1988 total financing of the Fund was derived from fines imposed upon uninsured employers.

Effective January 1, 1989, an amendment to the Law requires that the present financing be supplemented by a direct surcharge shown as a separate "Uninsured Employers Fund Surcharge" line on your policy Information Page. This method will assure the delivery of benefits to injured workers and the surcharge will cease whenever the year end balance of the Fund exceeds $500,000.

DISCLOSURE FORM
WORKERS COMPENSATION INSURANCE

IMPORTANT NOTICE TO POLICYHOLDER

1. NOTIFICATION OF CHANGE IN RATE BY CLASSIFICATION

If you desire information whenever there is a change in your workers' compensation insurance rate by classification, you may request such information from your insurer. This request for information must be in writing. Your insurer is required to supply this information within thirty (30) days following release of such information to your insurer by the authorized rating organization and following approval of the rate change by classification.

2. NOTICE OF POLICYHOLDERS' RIGHT TO APPEAL CLASSIFICATION

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

If you have any questions regarding the employee classification assigned to calculate your workers' compensation insurance premium, you need to direct your questions to your insurer or the insurers authorized representative. Your insurer or the insurers authorized representative must explain to you why a particular employee classification was used to eliminate any possible confusions.

If you still disagree with your insurer or the insurers authorized representative on the employee classification assignment, you must ask, in writing, that the classification assignment be reviewed. Your request to review the classification assignment must be directed to the Colorado Classification and Rating (C. & R.) Committee, National Council on Compensation Insurance (NCCI), P.O. Box 5323, Denver, Colorado 80217-5323. Written instruction for your appearance before the C. & R. Committee will be furnished by such committee. A decision as to whether a misclassification has occurred will be rendered by the C. & R. Committee.

If you disagree with the decision made by the C. & R. Committee, you have the right to request a redetermination of such decision by the Colorado Division of Insurance, First Western Plaza Building, Suite 500, 303 West Colfax Avenue, Denver, Colorado 80204. This request for redetermination must be in writing and directed to Christel L. Szczesniak. The final administrative decision as to whether a misclassification occurred will be made by the Colorado Division of Insurance.

3. NOTICE OF AVAILABILITY OF MEDICAL CASE MANAGEMENT SERVICES

On appropriate cases, staff Health Service Representatives (R.N.'s) or outside vendors are assigned for medical case management to insure quality medical care and rehabilitation at a reasonable cost. The use includes, but is not limited to, coordinating with qualified medical providers, monitoring the rehabilitation process and working with employers to return the injured party to their regular or a modified position.

TO OUR POLICYHOLDERS:

Colorado House Bill 1212 requires that companies providing Workers' Compensation Coverage in Colorado make available their risk management services in order that all insureds may establish a formal risk management program. If your company is interested in establishing such a program, please contact your independent agent and they will see to it that this material is provided to you.

TO OUR MINNESOTA INSUREDS

The Hartford has a program available that would allow you as an employer to pay small Workers' Compensation claims in return for a reduction in your premium. This is a deductible program in which we will continue to handle all claims for you, then bill you for the amount of the claim within the deductible. All claims within or above the deductible level will continue to be reported for the purposes of determining your experience modification if you qualify for that program.

Should you be interested in such a program please contact your Hartford agent for the details on how this program would effect your insurance program.

Form WC 66 01 30 A Printed in U.S.A.

TO OUR POLICYHOLDERS:

South Dakota Senate Bill 191, requires that companies providing Workers' Compensation Coverage in South Dakota make available their risk management services in order that all insureds may establish a formal risk management program. If your company is interested in establishing such a program please contact your independent agent and they will see to it that this material is provided to you.

ARIZONA NOTICE
INDEPENDENT CONTRACTORS

Section 23-902 of the Arizona statutes states that a contractor is deemed an employee of the "employer" for which they are working if:

- The employer retains supervision or control over the contractor

and

- The work is ongoing, regular, ordinary, or routine in your operation and is routinely done by your own employees

If the above conditions are met, we will treat the contractor as an employee and make the appropriate premium charge.

Section 23-964, Section L of the Arizona statutes allows a contractor who is a sole proprietor to waive rights to Workers Compensation coverage. No additional premium charge will be made, if the sole proprietor completes form WC 66 02 35 "Arizona Sole Proprietor Waiver".

For further information, please contact your agent or broker.

TEXAS IMPORTANT NOTICE

Effective 1-1-96 the W.C. law changed in regard to Sole Proprietors, Partners, and Executive Officers. The **new** law **automatically covers** these individuals unless specifically excluded. Prior to 1-1-96 these individuals were automatically excluded from coverage unless they were endorsed on the policy as covered.

Our W.C. policies are being issued to cover all Sole Proprietors, Partners, and Executive Officers. If coverage is not desired, please notify us immediately and we will endorse the file to specifically exclude coverage.

IMPORTANT NOTICE TO OUR POLICYHOLDERS

As required by Florida law, statute number 440.381, paragraph 4, you are required to file with your insurance carrier on a quarterly basis: UTC 6 and a current list of employees.

Failure to do so, could result in your policy being cancelled.

If you have any questions, please contact your Insurance Agent.

WORKPLACE SAFETY COMMITTEE
"CERTIFICATION RENEWAL AFFIDAVIT"

Section 1002.B. of the Act 57 amendments to the Workers' Compensation Law states that:

"Upon the renewal of the employer's workers' compensation policy next following receipt of Department certification, the employer shall receive a five per centum discount in the rate or rates applicable to the policy for a period of one year. The five per centum discount shall continue for a total of five years if the employer, by affidavit, provides annual verification to the Department and to the employer's insurer that the safety committee continues to be operative and continues to meet the certification requirements. "

THE FOLLOWING QUESTIONS AND ANSWERS EXPLAIN THE PROCEDURES FOR CERTIFICATION RENEWAL:

How do I obtain a certification renewal affidavit? "Certification Renewal Affidavits " will be automatically computer generated and mailed to all employers whose workplace safety committees have been initially certified.

When will affidavits be mailed? Affidavits will be mailed to insured employers approximately 60-90 days before their workers' compensation insurance premium renewal date and mailed to group self-insurance fund members approximately 60-90 days before the end of their annual fund year.

What information will be included on affidavits? Affidavits will have all of the following already completed: name, address, contact person, carrier information, union data, self-insurance information, workplace location and safety committee data. This information is taken from the certification application initially approved, and employers are asked to make any necessary corrections or changes and to complete any missing information. The affidavit also includes a series of questions about the continuing operation of the safety committee that can be answered by circling "YES" or "NO". Also included is an "Acknowledgments and Agreements " page which must be signed and the signature notarized.

Is completing and returning the affidavit all I need to do? If, since the initial certification, an employer has added workplaces which are not covered by a safety committee, a satisfactory explanation will be required for the affidavit to be approved. Also, if any additional safety committees have been established which have not previously been certified, a complete initial "Application for Certification of Workplace Safety Committee " is required for these new committees. These application should be submitted along with the completed renewal affidavit for review, and both must be approved to be eligible for the renewal discount.

If my affidavit is approved, who will be notified? Each employer will be notified in writing that their affidavit has been approved. If the employer is insured, it is their responsibility to provide a copy of the notification to their insurer. For each employer whose certification renewal is approved, the Pennsylvania Compensation Rating Bureau (PCRB) will also be notified. It is then up to the insurer and PCRB to calculate and apply the discount. If the employer is a member of a group self-insurance fund which has approved discounts in member contributions, the fund administrator will be notified of the certification renewal approval.

What happens if my affidavit is not approved? Each applicant will receive written notification if their affidavit is disapproved. The notification will state the specific reasons for disapproval. If these deficiencies can be remedied through, for example, the submission of acceptable documentation, prior to the premium renewal date or end of the annual fund year, the affidavit can then be approved.

Affidavits are already being mailed to employers with certified committees whose premium renewal dates fall between August 23rd and September 30th. Employers should allow at least 20 working days for processing of certification renewal affidavits.

If you have any further questions concerning the "Certification Renewal Affidavit ", please contact the Certification Unit at (717) 772-1635 or the Health and Safety Section at (717) 772-1917.

8/96

PENNSYLVANIA WORKERS' COMPENSATION REFORM

Act 57 of the Pennsylvania law lengthens the period of time during which you may require an injured employee to seek treatment from a health care provider designated by the employer. Effective August 23, 1996, the period was lengthened from 30 days to 90 days after the date of the first visit to a designated health care provider.

Under the terms of the law, you MAY NOT DIRECT an injured worker to a health care provider during such 90 day period UNLESS first obtaining written acknowledgment from the employee indicating that the employee has been informed of and understands his or her rights and obligations under the provisions of section 306 (F.1)(1)(1) of the Workers' Compensation Act. If you fail to obtain such written acknowledgment, an injured employee is entitled to treatment from a medical care provider of his or her choice. The Hartford will be responsible for paying the cost of such treatment. However, because such treatment will be more expensive, you should be advised that it could adversely impact your future insurance cost.

Attached is a sample of a FORM WHICH WE ENCOURAGE YOU TO USE to inform employees of their rights and obligations under the law and which can be used to obtain their written acknowledgment of such rights and responsibilities.

IF YOU HAVE NOT ESTABLISHED A PANEL OF PHYSICIANS, WE CAN BE OF ASSISTANCE. The Hartford currently utilizes FIRST HEALTH as their medical network for the state of Pennsylvania. FIRST HEALTH is one of the nation's largest preferred provider organizations offering a network of Workers' Compensation focused providers and comprehensive array of services, industrial medical clinics and work hardening centers. You may contact The Hartford's Network Referral Unit directly at 1-800-327-3636, option 4, to obtain a list of treating physicians.

We appreciate your cooperation and encourage you to utilize our Hartford LossConnect reporting system. (1-800-327-3636) to report your losses with 24 hours.

Form WC 66 02 67 A Printed in U.S.A.

IMPORTANT NOTICE

This Notice shall service to advise you of your rights and responsibilities under the Pennsylvania Workers' Compensation Act.

If you sustain a work-related injury requiring medical treatment, you are required to first treat with a doctor who is on a list of six (6) providers identified below. You are required to treat with that provider for ninety (90) days from the first visit. However, if invasive surgery is recommended by the designated physician, then you are allowed a second opinion by a physician of your choice. If the second opinion differs from the first, you have the right to determine which course of treatment to follow, provided that the second opinion provides a specific and detailed course of treatment. If you choose to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the second opinion visit. Treatment with your own medical provider in violation of the above may result in your medical bills being unpaid for the prescribed period. Upon expiration of the prescribed period, if you select a medical provider not on the panel below, you must notify your employer of your choice of providers within five (5) days of the first visit or risk non-payment of those medical bills until proper notice is given. Your employer's approved providers are:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

The name of your employer's insurance carrier is:

The Hartford
P.O. Box 4771
Syracuse, NY 13221
1-877-469-9222

Please sign where indicated to verify that you understand the rights and responsibility outlined in this Notice.

I, _____,
have read the above and understand the rights
and responsibilities explained to me therein.

_____ _____

Signature of Employee/Date Witness/Date

IMPORTANT NOTICE

THE TENNESSEE STATE WORKER'S COMPENSATION LAW REQUIRES THAT COMPENSATION BE PAID WITHIN FIFTEEN (15) DAYS AFTER THE EMPLOYER HAS KNOWLEDGE OF ANY DISABILITY OR DEATH. FAILURE TO COMPLY WITH THIS PROVISION RESULTS IN A PENALTY OF 6% BEING ADDED TO THE UNPAID COMPENSATION INSTALLMENT.

THIS 6% PENALTY, IF IT IS A RESULT OF THE EMPLOYER NOT ADVISING HIS INSURANCE CARRIER PROMPTLY, MAY BE REFLECTED DIRECTLY IN THE EMPLOYER'S WORKER'S COMPENSATION INSURANCE COST.

IMMEDIATE REPORTING OF ALL INJURIES CAN SAVE YOU MONEY ON YOUR INSURANCE COSTS.

IMPORTANT NOTICE
Effective July 1, 1978

The Georgia Workers' Compensation Law requires that compensation payments to injured workers begin within fourteen days after the employer has knowledge of the accident. If a delay is due to your failure to report a claim to the company the penalty will be paid by you. Your Insurance carrier will not reimburse you.

To avoid any possibility of a substantial penalty, report all accidents and claims to our claims representative immediately. If you are unable to contact our claim representative, notify your agent and ask him/her to see that the claim report is made out and filed without delay

Form WC 66 02 75 Printed in U.S.A.

NOTICE OF INSURED'S RIGHTS

If you are insured under a workers' compensation insurance policy and believe that the rates or the rating system will cause you harm, you may request a review of the manner in which the rate or rating system has been applied. You must make your request in writing to the insurance company or advisory organization. The insurance company or advisory organization has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, the insurance company or advisory organization shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of the review. Your appeal is to be sent to:

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

Your request for an appeal should include a statement of the facts and the reasons why the rates or rating system should be changed. Also, enclose copies of the results of the review and any other correspondence from the insurance company or advisory organization. If your appeal shows good cause, the Commissioner shall hold a hearing. The commissioner may after the hearing issue a final order affirming, modifying, or reversing the action of the insurance company or advisory organization.

IMPORTANT NOTICE

THE NEW HAMPSHIRE STATE WORKER'S COMPENSATION LAW REQUIRES THAT A WRITTEN EMPLOYER'S REPORT OF INJURY BE MADE WITHIN FIVE DAYS

AN EMPLOYER WHO FAILS TO COMPLY IS SUBJECT TO A PENALTY OF UP TO $2,500.

IMPORTANT NOTICE

Chapter 525, Section 110 of the New York Workers' Compensation Law requires that a written Employer's Report of Work-Related Accident/Occupational Disease (Form C-2) be made in ten days after the occurrence of an accident.

An employer who fails to comply with this requirement is subject to a fine of up to $2,500 and up to one year imprisonment.

STATE OF MISSOURI
WORKERS' SAFETY PROGRAMS (MWSP)

The State of Missouri Division of Workers' Compensation requires all insurance carriers to notify policyholders about MWSP's services in the same manner as it notifies policyholders about its own internal loss control services. MWSP requires insurance carriers to provide the following notice to its policyholders:

The Missouri Division of Workers' Compensation offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goal is to help employers control workers' compensation costs. The Division also certifies Missouri insurance carriers' safety engineering and management programs that are available to insured's upon request. Employers may contact MWSP at 1 (800) 775-COMP or 573/526-3504, email mowsp@dolir.mo.gov for more information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

ARKANSAS CERTIFICATE OF NONCOVERAGE LAW POLICYHOLDER NOTICE

If you hire subcontractors (called an intermediate subcontractor) that do not have Workers Compensation coverage and they, in turn, hire subcontractors that do not have Workers Compensation coverage, the Certificate of Noncoverage for the subcontractors hired by your intermediate subcontractor will not satisfy the state's regulations. You will be charged the exposure for both the intermediate subcontractor and any subcontractors they hire.

If the intermediate subcontractors you hire have Workers Compensation coverage, the Certificate of Noncoverage for the subcontractors they hire will satisfy the state's regulations and you will not be charged for the intermediate subcontractors or the subcontractors they hire on your policy.

NEW YORK WORKERS COMPENSATION

OCTOBER 1, 2013 RATE REVISION - Property and Casualty Insurance Company of Hartford

EXPLANATORY MEMORANDUM

An overall loss cost level increase of 9.5%, which includes an increase of 9.9% in the average manual loss cost level and no change in the loss costs for terrorism and natural disasters and catastrophic industrial accidents, has been approved by the New York State Department of Financial Services to become effective on October 1, 2013.

Loss Experience – The latest two policy years of experience produced a 9.1% increase in the overall loss cost level.

Legislative and Regulatory Changes – This revision includes an estimate of the latest cost of the increases in the maximum weekly benefits that were set forth in the 2007 workers compensation reform legislation. In addition, the 2013 enacted New York State Budget provides for the elimination of the Reopened Case Fund and for the increase in the minimum weekly benefits. The combined overall impact of these changes is an increase of 5.3% in manual loss costs.

Loss Adjustment Expenses – A review of the latest data available resulted in a 1.4% decrease in the Loss Adjustment Expense provision.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a continuing small decrease in claim frequency and an upward trend in both indemnity and medical claim costs. Combined with a projected wage trend, the resulting net trend factor is -2.3%.

Catastrophe Provision – This revision contains no changes in the loss cost for terrorism and in the loss cost for natural disasters and catastrophic industrial accidents.

Classification Loss Costs – Although the average manual loss cost level is increasing by 9.9%, individual classification loss cost changes are based on the most recently available loss experience for each classification. Both increases and decreases from the current loss costs have been actuarially calculated for each class. This process ensures that each classification loss cost reflects the appropriate level relative to the experience of the other classifications.

NEW YORK WORKERS COMPENSATION
RATE COMPARISON - OCTOBER 1, 2013 TO APRIL 1, 2013

PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change
0005	3.34	3.85	-13.2%
0006	8.13	8.04	1.1%
0007	7.15	5.28	35.4%
0031	6.06	6.72	-9.8%
0034	6.03	6.67	-9.6%
0035	3.69	3.40	8.5%
0042	9.47	10.21	-7.2%
0050	6.39	5.80	10.2%
0106	19.91	19.84	0.4%
0251	10.74	9.54	12.6%
0767	2.42	1.49	62.4%
0771	6.18	5.02	23.1%
0908	126.10	106.86	18.0%
0909	255.90	194.07	31.9%
0912	1140.06	1082.89	5.3%
0913	475.83	423.20	12.4%
0917	7.47	6.88	8.6%
1170	7.27	8.32	-12.6%
1320	11.96	8.83	35.4%
1430	11.17	11.68	-4.4%
1438	6.58	7.15	-8.0%
1439	9.67	10.28	-5.9%
1452	8.10	8.01	1.1%
1463	11.28	12.08	-6.6%
1470	17.27	14.82	16.5%
1624	6.14	6.00	2.3%
1701	8.29	6.91	20.0%
1710	8.71	9.81	-11.2%
1741	11.64	11.56	0.7%
1747	27.64	20.54	34.6%
1748	11.06	8.98	23.2%
1809	14.95	13.82	8.2%
1810	15.16	13.86	9.4%
1853	6.33	5.36	18.1%
1860	15.93	11.84	34.5%
1924	11.16	11.96	-6.7%
1925	8.51	6.33	34.4%
2001	10.80	7.64	41.4%
2002	9.21	6.51	41.5%
2003	9.87	9.36	5.4%
2014	8.95	9.69	-7.6%
2021	6.85	5.39	27.1%
2039	7.55	5.96	26.7%
2041	5.87	5.54	6.0%
2065	8.23	7.46	10.3%
2070	9.48	8.14	16.5%
2081	21.87	19.42	12.6%
2089	12.96	9.15	41.6%
2095	14.73	13.88	6.1%
2101	7.50	7.73	-3.0%
2105	9.73	9.44	3.1%
2111	8.83	9.64	-8.4%
2112	10.48	7.40	41.6%
2114	8.49	7.13	19.1%
2121	8.60	6.08	41.4%
2143	7.09	5.87	20.8%
2150	13.94	11.04	26.3%
2157	16.88	11.93	41.5%
2172	3.03	2.32	30.6%
2211	13.70	14.95	-8.4%
2286	7.64	7.39	3.4%
2288	17.43	14.86	17.3%
2302	8.68	8.31	4.5%
2303	11.07	11.67	-5.1%
2305	14.77	16.30	-9.4%
2362	3.21	2.99	7.4%
2380	15.22	11.31	34.6%
2383	4.93	4.56	8.1%
2387	5.17	4.15	24.6%
2388	6.06	5.01	21.0%
2402	3.64	3.17	14.8%
2413	7.64	7.19	6.3%
2416	2.84	2.41	17.8%
2417	7.71	6.67	15.6%
2501	1.62	1.71	-5.3%
2503	1.47	1.20	22.5%
2534	6.24	4.93	26.6%
2553	3.60	3.73	-3.5%
2570	8.47	9.06	-6.5%
2571	5.77	4.28	34.8%

NEW YORK WORKERS COMPENSATION
RATE COMPARISON - OCTOBER 1, 2013 TO APRIL 1, 2013

PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change
2576	11.15	9.36	19.1%
2578	5.25	4.43	18.5%
2590	4.12	3.97	3.8%
2591	7.25	7.59	-4.5%
2593	7.74	7.98	-3.0%
2594	9.50	6.91	37.5%
2600	8.37	7.39	13.3%
2623	7.86	6.49	21.1%
2640	20.14	14.96	34.6%
2660	6.05	5.26	15.0%
2670	6.33	5.22	21.3%
2683	6.57	5.50	19.5%
2688	2.62	2.36	11.0%
2689	1.25	1.01	23.8%
2702	64.46	58.85	9.5%
2710	11.92	12.16	-2.0%
2714	17.89	15.07	18.7%
2731	8.46	7.19	17.7%
2735	5.94	5.53	7.4%
2737	13.54	10.88	24.4%
2759	18.31	18.66	-1.9%
2790	6.32	6.87	-8.0%
2802	9.35	7.98	17.2%
2816	7.73	5.74	34.7%
2817	8.53	7.18	18.8%
2818	7.43	6.43	15.6%
2835	5.66	5.53	2.4%
2841	7.53	7.56	-0.4%
2881	6.29	5.71	10.2%
2883	7.61	8.04	-5.3%
2913	3.82	3.25	17.5%
2916	7.04	6.37	10.5%
2923	2.72	2.21	23.1%
2942	3.17	2.79	13.6%
3004	11.99	10.76	11.4%
3018	17.73	13.17	34.6%
3022	15.57	16.72	-6.9%
3027	2.32	1.77	31.1%
3028	13.18	9.79	34.6%
3030	12.41	11.96	3.8%
3040	13.58	13.70	-0.9%
3041	8.14	7.09	14.8%
3042	11.23	11.16	0.6%
3060	32.97	28.99	13.7%
3064	12.27	9.38	30.8%
3066	5.84	6.33	-7.7%
3067	10.77	10.43	3.3%
3076	7.98	7.16	11.5%
3081	24.92	26.45	-5.8%
3085	13.95	14.07	-0.9%
3110	16.73	13.28	26.0%
3111	10.42	9.61	8.4%
3113	4.80	3.57	34.5%
3114	3.14	2.63	19.4%
3118	4.49	4.50	-0.2%
3122	11.37	10.92	4.1%
3126	19.70	17.33	13.7%
3129	8.43	7.85	7.4%
3132	4.92	3.94	24.9%
3145	4.24	4.26	-0.5%
3146	5.29	5.08	4.1%
3169	4.13	3.51	17.7%
3179	4.81	4.55	5.7%
3188	8.37	7.03	19.1%
3190	4.35	3.25	33.8%
3191	4.59	3.42	34.2%
3200	5.07	4.47	13.4%
3220	7.12	7.94	-10.3%
3227	59.22	55.12	7.4%
3241	9.91	8.78	12.9%
3255	6.66	6.91	-3.6%
3257	5.66	5.32	6.4%
3270	3.49	3.34	4.5%
3300	6.39	6.57	-2.7%
3303	11.26	12.66	-11.1%
3307	7.80	5.80	34.5%
3315	7.33	6.21	18.0%
3336	3.82	3.92	-2.6%
3365	12.35	14.21	-13.1%
3372	6.81	5.63	21.0%

NEW YORK WORKERS COMPENSATION
RATE COMPARISON - OCTOBER 1, 2013 TO APRIL 1, 2013

PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change
3381	5.04	4.81	4.8%
3383	1.53	1.38	10.9%
3384	0.52	0.48	8.3%
3385	1.95	1.65	18.2%
3400	12.76	9.48	34.6%
3507	5.48	4.76	15.1%
3515	5.35	4.77	12.2%
3548	4.87	4.16	17.1%
3559	3.54	2.63	34.6%
3561	3.39	2.91	16.5%
3574	2.54	2.53	0.4%
3581	3.14	2.65	18.5%
3612	5.56	5.05	10.1%
3620	9.47	9.48	-0.1%
3629	4.43	4.71	-5.9%
3632	6.54	6.40	2.2%
3634	5.07	5.41	-6.3%
3635	4.38	3.57	22.7%
3638	4.22	3.61	16.9%
3642	3.12	2.39	30.5%
3643	5.71	4.24	34.7%
3647	7.73	6.78	14.0%
3648	6.21	5.47	13.5%
3681	2.85	2.69	5.9%
3685	2.76	2.29	20.5%
3686	2.57	2.17	18.4%
3724	9.87	10.62	-7.1%
3726	21.37	22.25	-4.0%
3737	7.52	7.98	-5.8%
3807	6.92	5.47	26.5%
3808	5.90	6.06	-2.6%
3821	16.57	17.65	-6.1%
3823	15.17	11.86	27.9%
3824	6.27	5.94	5.6%
3826	4.10	3.61	13.6%
3827	10.77	9.38	14.8%
3830	6.64	5.26	26.2%
3832	4.89	5.19	-5.8%
3865	3.76	3.36	11.9%
3881	a	a	

Class Code	Oct.2013	Apr.2013	% Change
4000	7.74	8.31	-6.9%
4024	8.44	6.27	34.6%
4034	19.84	17.19	15.4%
4038	6.63	4.92	34.8%
4053	16.78	18.55	-9.5%
4061	12.11	10.48	15.6%
4062	9.99	8.29	20.5%
4101	5.13	4.40	16.6%
4111	5.65	5.13	10.1%
4112	4.95	4.12	20.1%
4114	6.15	5.87	4.8%
4130	12.05	10.83	11.3%
4131	5.97	5.08	17.5%
4133	2.59	2.36	9.7%
4150	2.91	2.33	24.9%
4207	2.21	1.89	16.9%
4239	7.98	5.93	34.6%
4240	7.52	6.45	16.6%
4243	6.85	6.58	4.1%
4244	6.69	6.45	3.7%
4250	5.05	5.35	-5.6%
4251	6.40	5.54	15.5%
4263	5.45	4.41	23.6%
4273	5.53	5.90	-6.3%
4279	7.03	7.46	-5.8%
4282	0.98	0.73	34.2%
4298	3.12	2.51	24.3%
4299	4.98	4.53	9.9%
4301	7.65	6.79	12.7%
4304	9.44	7.21	30.9%
4307	4.62	3.76	22.9%
4310	5.20	4.71	10.4%
4312	3.33	3.25	2.5%
4351	2.66	2.39	11.3%
4352	1.22	1.35	-9.6%
4360	0.46	0.43	7.0%
4361	1.50	1.43	4.9%
4362	0.82	0.73	12.3%
4410	11.69	12.60	-7.2%
4420	17.01	17.70	-3.9%

NEW YORK WORKERS COMPENSATION
RATE COMPARISON - OCTOBER 1, 2013 TO APRIL 1, 2013

PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change	Class Code	Oct.2013	Apr.2013	% Change
4431	6.98	6.64	5.1%	5057	23.05	19.82	16.3%
4432	2.81	2.39	17.6%	5059	44.40	52.23	-15.0%
4439	2.15	1.84	16.8%	5069	70.63	90.07	-21.6%
4452	6.61	5.48	20.6%	5102	19.04	20.00	-4.8%
4459	7.03	6.29	11.8%	5160	9.87	12.68	-22.2%
4470	5.17	5.77	-10.4%	5183	11.03	11.25	-2.0%
4475	6.26	6.49	-3.5%	5184	11.99	10.30	16.4%
4476	4.53	3.57	26.9%	5188	7.74	6.70	15.5%
4479	4.32	3.89	11.1%	5190	9.03	8.16	10.7%
4491	9.60	9.75	-1.5%	5191	2.50	2.01	24.4%
4493	9.02	7.10	27.0%	5192	10.06	9.44	6.6%
4511	1.10	1.07	2.8%	5193	20.43	20.63	-1.0%
4557	4.15	3.67	13.1%	5213	25.01	24.64	1.5%
4558	4.89	6.06	-19.3%	5221	17.42	17.82	-2.2%
4561	8.11	8.92	-9.1%	5222	22.91	27.57	-16.9%
4568	4.67	5.80	-19.5%	5223	13.26	12.04	10.1%
4583	20.61	17.09	20.6%	5348	10.46	10.76	-2.8%
4597	4.83	4.50	7.3%	5402	15.71	18.56	-15.4%
4611	3.97	3.70	7.3%	5403	18.00	20.66	-12.9%
4628	2.53	2.05	23.4%	5428	17.10	14.96	14.3%
4635	8.10	6.39	26.8%	5429	10.28	11.16	-7.9%
4653	4.31	3.37	27.9%	5443	13.24	13.36	-0.9%
4665	16.08	13.43	19.7%	5445	12.72	13.24	-3.9%
4692	1.22	1.29	-5.4%	5462	18.77	19.45	-3.5%
4693	6.49	4.83	34.4%	5473	39.69	34.15	16.2%
4710	6.43	6.09	5.6%	5474	14.07	15.57	-9.6%
4712	6.81	5.53	23.1%	5479	12.07	11.31	6.7%
4720	5.99	5.50	8.9%	5480	8.69	10.42	-16.6%
4751	5.38	4.77	12.8%	5491	5.17	4.55	13.6%
4767	9.90	9.26	6.9%	5506	24.31	20.71	17.4%
4771	12.45	12.54	-0.7%	5507	18.44	19.51	-5.5%
4825	1.72	2.14	-19.6%	5508	8.89	10.10	-12.0%
4828	3.08	3.25	-5.2%	5536	12.42	11.01	12.8%
4829	4.04	4.26	-5.2%	5538	16.51	14.09	17.2%
4902	5.51	4.78	15.3%	5545	37.98	37.37	1.6%
4923	3.15	3.18	-0.9%	5547	29.04	34.19	-15.1%
5000	40.26	42.62	-5.5%	5606	5.14	6.12	-16.0%
5022	23.85	22.07	8.1%	5610	10.80	9.24	16.9%
5037	41.73	44.06	-5.3%	5645	16.88	17.65	-4.4%
5040	41.04	36.64	12.0%	5648	24.61	25.01	-1.6%

NEW YORK WORKERS COMPENSATION
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PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change
5651	10.55	13.03	-19.0%
5701	21.95	18.81	16.7%
5703	23.43	19.45	20.5%
5709	20.43	27.80	-26.5%
5951	1.84	1.99	-7.5%
5954	5.69	4.90	16.1%
6003	24.43	20.92	16.8%
6005	7.98	6.78	17.7%
6017	3.67	4.03	-8.9%
6018	22.22	22.77	-2.4%
6045	5.68	5.93	-4.2%
6204	19.21	21.03	-8.7%
6216	12.04	10.31	16.8%
6217	12.11	12.63	-4.1%
6229	9.08	9.97	-8.9%
6233	9.45	11.46	-17.5%
6235	12.39	14.58	-15.0%
6251	18.71	25.46	-26.5%
6252	5.02	6.27	-19.9%
6260	a	a	
6306	19.18	19.21	-0.2%
6319	12.32	12.38	-0.5%
6325	13.30	11.29	17.8%
6400	13.17	16.63	-20.8%
6504	9.50	7.89	20.4%
6701	18.20	20.58	-11.6%
6801	35.80	35.72	0.2%
6811	11.47	12.35	-7.1%
6824	16.60	12.27	35.3%
6826	3.76	3.97	-5.3%
6834	5.72	5.59	2.3%
6836	6.32	5.56	13.7%
6843	5.47	5.41	1.1%
6854	3.77	3.85	-2.1%
6872	40.79	47.88	-14.8%
6874	71.82	53.12	35.2%
6875	91.76	82.37	11.4%
6882	6.94	7.53	-7.8%
6884	54.70	55.52	-1.5%
6885	76.96	77.96	-1.3%
7016	9.01	6.66	35.3%
7024	9.99	7.39	35.2%
7038	5.20	3.91	33.0%
7046	8.08	6.03	34.0%
7047	15.53	11.49	35.2%
7050	8.04	6.42	25.2%
7090	5.77	4.34	32.9%
7098	8.98	6.70	34.0%
7099	12.50	9.93	25.9%
7133	6.45	6.54	-1.4%
7197	8.50	8.59	-1.0%
7201	8.34	7.15	16.6%
7207	5.31	5.20	2.1%
7219	16.17	14.93	8.3%
7231	14.95	14.92	0.2%
7242	30.24	21.99	37.5%
7309	13.02	15.28	-14.8%
7313	2.32	2.27	2.2%
7317	23.69	20.85	13.6%
7327	26.24	26.96	-2.7%
7333	12.90	9.54	35.2%
7335	14.33	10.60	35.2%
7337	21.22	15.69	35.2%
7364	6.43	4.89	31.5%
7366	17.94	18.58	-3.4%
7367	17.13	14.58	17.5%
7368	10.52	9.17	14.7%
7370	a	a	
7377	11.19	8.83	26.7%
7380	14.55	11.50	26.5%
7390	12.50	9.02	38.6%
7394	7.70	5.69	35.3%
7395	8.53	6.32	35.0%
7398	12.02	9.36	28.4%
7403	8.23	6.42	28.2%
7405	3.24	2.79	16.1%
7421	2.10	1.95	7.7%
7422	3.25	2.41	34.9%
7431	1.69	1.46	15.8%
7445	0.65	0.62	4.8%

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PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

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7453	0.62	0.59	5.1%
7502	2.17	1.69	28.4%
7515	1.80	1.71	5.3%
7520	8.19	9.18	-10.8%
7536	12.23	12.56	-2.6%
7538	17.28	20.08	-13.9%
7539	2.45	2.32	5.6%
7542	6.95	5.13	35.5%
7570	2.50	2.51	-0.4%
7580	7.13	5.26	35.6%
7590	5.53	5.54	-0.2%
7600	8.23	7.25	13.5%
7601	13.83	13.94	-0.8%
7610	0.67	0.53	26.4%
7710	6.00	5.50	9.1%
7711	E	E	
7716	E	E	
7720	1.95	2.14	-8.9%
7723	3.12	3.00	4.0%
7855	7.62	9.55	-20.2%
7998	4.12	3.54	16.4%
7999	3.42	3.12	9.6%
8001	3.37	2.44	38.1%
8006	2.72	2.47	10.1%
8008	1.69	1.55	9.0%
8012	2.05	1.56	31.4%
8013	0.59	0.62	-4.8%
8016	0.48	0.39	23.1%
8017	2.18	1.93	13.0%
8018	6.05	5.02	20.5%
8021	7.59	7.59	0.0%
8025	3.77	3.24	16.4%
8031	4.37	3.94	10.9%
8032	1.69	1.52	11.2%
8033	5.53	4.58	20.7%
8034	11.35	11.34	0.1%
8039	4.80	4.29	11.9%
8043	1.66	1.58	5.1%
8044	5.80	5.32	9.0%
8046	6.48	6.08	6.6%
8047	2.81	2.30	22.2%
8048	8.19	7.55	8.5%
8068	1.10	1.03	6.8%
8069	1.75	1.55	12.9%
8072	1.92	1.93	-0.5%
8090	2.26	1.65	37.0%
8102	9.12	8.83	3.3%
8103	6.49	5.97	8.7%
8105	4.89	4.59	6.5%
8106	11.09	10.60	4.6%
8107	6.52	5.56	17.3%
8111	7.18	7.40	-3.0%
8116	5.71	4.12	38.6%
8199	5.60	5.36	4.5%
8209	11.41	8.90	28.2%
8215	17.62	15.05	17.1%
8227	17.83	16.42	8.6%
8232	8.92	8.14	9.6%
8235	12.29	12.96	-5.2%
8263	12.14	13.08	-7.2%
8264	15.11	13.11	15.3%
8265	13.72	13.69	0.2%
8280	19.35	14.27	35.6%
8288	5.36	3.88	38.1%
8291	14.58	13.61	7.1%
8292	12.66	11.23	12.7%
8293	18.31	14.47	26.5%
8350	14.87	10.74	38.5%
8353	8.38	6.05	38.5%
8381	4.24	4.70	-9.8%
8382	4.37	4.46	-2.0%
8385	11.96	12.19	-1.9%
8391	6.37	5.90	8.0%
8392	3.22	3.30	-2.4%
8394	9.58	7.49	27.9%
8500	11.87	12.41	-4.4%
8601	0.98	1.03	-4.9%
8709	21.73	18.41	18.0%
8719	3.25	3.40	-4.4%
8720	3.46	3.25	6.5%
8726	3.60	3.25	10.8%
8731	3.42	2.70	26.7%
8742	0.64	0.58	10.3%
8745	12.47	9.01	38.4%

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PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

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8747	0.43	0.49	-12.2%
8748	1.87	1.49	25.5%
8751	6.30	6.49	-2.9%
8755	0.94	0.82	14.6%
8800	2.70	2.63	2.7%
8802	1.74	1.49	16.8%
8803	0.15	0.15	0.0%
8809	0.31	0.30	3.3%
8810	0.30	0.27	11.1%
8820	0.27	0.22	22.7%
8829	5.57	5.02	11.0%
8831	2.26	2.18	3.7%
8832	0.80	0.68	17.6%
8833	2.36	1.63	44.8%
8838	0.79	0.55	43.6%
8840	0.70	0.64	9.4%
8854	5.84	4.04	44.6%
8857	2.91	2.02	44.1%
8864	5.25	4.06	29.3%
8865	5.13	4.18	22.7%
8866	5.51	5.38	2.4%
8868	0.86	0.82	4.9%
8869	1.17	0.82	42.7%
8871	0.82	0.68	20.6%
8901	0.52	0.53	-1.9%
9014	8.62	7.79	10.7%
9015	4.90	4.24	15.6%
9016	13.24	10.97	20.7%
9019	3.02	3.39	-10.9%
9025	30.55	29.60	3.2%
9026	5.63	5.08	10.8%
9027	24.86	18.08	37.5%
9028	5.17	4.71	9.8%
9029	9.42	10.34	-8.9%
9030	7.22	6.76	6.8%
9040	7.65	8.40	-8.9%
9044	6.58	4.78	37.7%
9048	5.44	5.35	1.7%
9051	5.94	4.32	37.5%
9052	5.90	5.02	17.5%
9055	1.66	1.32	25.8%
9058	3.12	3.19	-2.2%
9059	9.94	6.88	44.5%
9060	2.75	2.94	-6.5%
9061	2.50	2.54	-1.6%
9063	1.38	1.34	3.0%
9065	1.17	0.94	24.5%
9071	3.03	2.63	15.2%
9072	3.33	3.27	1.8%
9074	1.99	2.02	-1.5%
9088	13.20	9.73	35.7%
9089	0.74	0.68	8.8%
9093	3.21	2.81	14.2%
9101	6.94	6.88	0.9%
9102	3.88	4.26	-8.9%
9149	2.67	2.21	20.8%
9157	6.72	6.37	5.5%
9158	2.62	2.91	-10.0%
9159	1.75	1.60	9.4%
9160	2.63	2.27	15.9%
9178	4.62	4.09	13.0%
9179	8.23	7.21	14.1%
9180	3.74	3.05	22.6%
9182	2.84	2.63	8.0%
9186	15.83	13.94	13.6%
9220	9.57	8.37	14.3%
9402	10.43	9.38	11.2%
9403	18.80	17.12	9.8%
9410	6.58	4.78	37.7%
9501	3.80	2.76	37.7%
9505	4.68	3.89	20.3%
9519	6.54	4.76	37.4%
9521	6.70	7.10	-5.6%
9522	4.21	4.41	-4.5%
9526	37.67	35.05	7.5%
9527	40.64	34.91	16.4%
9534	24.53	19.87	23.5%
9539	16.76	16.70	0.4%
9545	14.18	16.03	-11.5%
9549	4.71	5.33	-11.6%

NEW YORK WORKERS COMPENSATION
RATE COMPARISON - OCTOBER 1, 2013 TO APRIL 1, 2013

PROPERTY & CASUALTY INSURANCE COMPANY OF HARTFORD

Class Code	Oct.2013	Apr.2013	% Change	Class Code	Oct.2013	Apr.2013	% Change
9552	23.23	28.34	-18.0%	9610	1.04	0.98	6.1%
9553	12.69	14.40	-11.9%	9620	1.98	1.56	26.9%
9585	1.49	1.34	11.2%	9740	0.06	0.06	0.0%
9586	1.04	0.95	9.5%	9741	0.01	0.01	0.0%
9600	1.98	1.80	10.0%				

Legend:

a - Advisory loss cost for each individual risk must be obtained from the New York Compensation Rating Board.

b - Ambulance – Volunteer Service Company – Code 7370 change is -14.4%.

E - Volunteer Firefighters - Refer to Volunteer Firefighters schedule for rates; change is -5.3%.

AN IMPORTANT NOTICE TO WORKERS' COMPENSATION POLICYHOLDERS

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense. An effective loss prevention/ loss control program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations. As a service to you, our valued customer, the Loss Control-Department of The Hartford can assist you in establishing time-proven and cost effective loss prevention and loss control strategies. This folder outlines many of the services available to you, and provides a mechanism for you to request them. If you would like additional information or assistance, please complete and return the reply portion to us; or, contact your independent agent.

A WORD ABOUT OREGON-OSHA

As an Oregon employer you are required by the Oregon Safe Employment Act (ORS 654.001 to 654.295 and 654.991) to provide employees with a safe and healthful workplace. By working to prevent injuries, illnesses and other economic losses, your company and employees can prosper.

INSURER SAFETY PROGRAMS

To help you reduce your premium, your workers' compensation insurer must help you reduce the risk of injuries in your workplace. It is required by law to offer occupational safety and health loss prevention services to you, **at no additional cost**. These include on-site safety and health surveys when you request them.

On an annual basis your insurer is required to:

- Inform you about its occupational health and safety loss prevention programs;
- Offer to provide an on-site evaluation of your loss prevention needs;
- Provide assistance in evaluating records that may be pertinent to your firm's injury and illness experience;
- Explain the Oregon Safe Employment Act and rules that apply to your particular place of employment;
- Provide an evaluation of workplace design, layout and operation, and assistance with job-site modifications utilizing an ergonomic approach;
- Provide assistance in evaluation and improving an employer's safety management practices;
- Provide assistance in identifying health and safety training needs and available resources; and
- Offer to provide follow-up services for evaluating the effectiveness of the service provided.

The Hartford will provide free of charge an on-site evaluation of your loss prevention needs. To avail yourself of this service, or any other loss control needs you may have, contact The Hartford by writing to:

The Hartford
Loss Control
One Hartford Plaza
Hartford, CT. 06155
Mail Drop: COGS-2-45
e-mail: Diana.Banta1@thehartford.com
or by calling 860-547-7761

You have the right to make a complaint to the OR-OSHA Division if we fail to respond to your request for loss prevention services, or we otherwise fail to provide services as offered or required. You may contact Oregon-OSHA, Insurer Programs, 1750 NW Naito Pkwy., Suite 112, Portland, OR 97209-2533, or (503) 229-5910.

Your insurer must also provide you with a health and safety loss prevention plan if you have been placed in the "designated employer" category by OR-OSHA. These plans are designed to help you develop a safer and healthier workplace. For further information, contact OR-OSHA's Insurer Program Coordinator at (503) 229-5910.

AN IMPORTANT NOTICE TO WORKERS' COMPENSATION POLICYHOLDERS

PROTECT YOURSELF

To protect yourself as a workers' compensation insurance consumer, take these steps:

- **Shop around for your insurance. Compare costs:** Although the base premium is the same, the overhead charged by insurers ranges from 15 percent to over 50 percent. Also, look beyond costs. Find out what type of assistance the insurer will give if one of your workers is injured. Does the insurer have a good customer service record?
- **Look at all the factors that make up your rates and premium.** Periodically review all details of your policy, including classifications assigned your employees, payroll to be used, claims, reserves, audits and billings. If you believe your insurer is wrong, check with your agent, NCCI, or the Department of Consumer and Business Services, and, if necessary, appeal the insurer's action.
- **Support "fair reporting" for equitable rates.** The information used to determine your merit or experience rating and classification rate revisions originates with you and your business competitors. Therefore, it is important to promote full, proper reporting of payrolls.
- **Inquire about preferred group programs.** Many insurers offer reduced group pricing to members of trade associations. Ask your insurer and trade association about this type of program. Many smaller employers receive substantial benefits from these programs, such as lower mass-marketed pricing and outstanding safety engineering and loss prevention services.
- **Ask your insurer about medical cost reimbursement.** Employers can reimburse up to $500 of medical service provider costs on nondisabling claims. These costs are not charged to the employer's experience. Ask your insurer or agent to explain the program and how it could affect your rates.

HOW DO I GET HELP?

Contact your insurance agent or representative with any questions you have about choosing policies, interpreting your policy, and getting help to make your workplace safer. If it is necessary to go beyond your agent, contact your insurance company directly.

If your insurer does not provide the information or assistance you need, several organizations are available to help you.

For questions on occupational safety and health, contact:

Oregon Occupational Safety and Health Division

Department of Consumer and Business Services

350 Winter Street NE, Room 430

Salem, OR 97310-0220

(503) 378-3272 or toll free at 1-800-922-2689

For questions on your policy or pricing, contact:

Insurance Division

Department of Consumer and Business Services

350 Winter St., Room 440

Salem, OR 97301-3883

(503) 947-7980

For questions on the rating system, contact:

The National Council on Compensation Insurance

6975 S.W. Sandburg St., Suite 160

Tigard, OR 97223

(503) 624-5890 or toll free at 1-800-622-4123

IMPORTANT NOTICE TO MINNESOTA POLICYHOLDERS

The Minnesota Insurance Guaranty Association Act provides for assessments from licensed insurers for the payment of claims against insolvent insurers. This Act requires that premiums include the amount necessary to recover such assessments. If your premium includes this amount, your policy will reflect the percentage of the premium that represents the assessment.

Please contact your Hartford Agent or Broker if you would like further information.

The Hartford

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS INSURANCE FOR ANY REASON, PLEASE CONTACT YOUR HARTFORD AGENT. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number.

SERVICING OFFICE:
THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

If you have been unable to contact or obtain satisfaction from the agent or from The Hartford's servicing office, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the address below.

VIRGINIA BUREAU OF INSURANCE
P.O. Box 1157
Richmond, VA 23218
Telephone: (804) 371-9185
1-800-552-7945 (Virginia Residents Only)

Written correspondence is preferable so that a record of your inquiry is maintained.

WHEN CONTACTING YOUR AGENT, COMPANY OR THE BUREAU OF INSURANCE, HAVE YOUR POLICY NUMBER AVAILABLE.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your agent who is listed on the Declarations/Information Page of your policy, or on your binder or certificate of insurance.

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-392-7805

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
e-Mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

IMPORTANT INFORMATION FOR MISSOURI POLICYHOLDERS

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS POLICY, PLEASE CONTACT YOUR HARTFORD AGENT. If you have additional questions, you may contact The Hartford at the address stated below.

SERVICING OFFICE:

THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE MAKE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

WISCONSIN NOTICE OF RIGHT TO FILE A COMPLAINT

KEEP THIS WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** , a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

Form G-3143-0 Printed in U.S.A.

Process Date: 10/10/13 **Expiration Date:** 10/01/14

IMPORTANT NOTICE FOR FLORIDA POLICYHOLDERS

If you would like to present inquiries or obtain information about coverage or obtain assistance in resolving a complaint, please contact YOUR HARTFORD AGENT, or you may contact The Hartford at the number stated below.

SERVICING OFFICE:

THE HARTFORD
8711 UNIVERSITY EAST DRIVE
CHARLOTTE NC 28213
(877) 853-2582

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE BE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

IMPORTANT INFORMATION FOR ILLINOIS POLICYHOLDERS

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS POLICY, PLEASE CONTACT YOUR HARTFORD AGENT.

If you have a complaint, you may contact The Hartford at the address stated below.

The Hartford
Customer Relations Department
Hartford Plaza
Hartford, CT 06115
Telephone: 1-800-727-0721

If you have been unable to contact or obtain satisfaction from your agent or from The Hartford's Customer Relations Department, you may contact the Illinois Department of Insurance at the address below.

ILLINOIS DEPARTMENT OF INSURANCE
Consumer Services Section
Springfield, IL 62767

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE MAKE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

IMPORTANT NOTICE FOR MARYLAND POLICYHOLDERS

Our Practices Regarding a Policyholder's Claim History

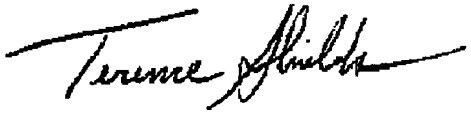
Pursuant to Maryland Insurance Laws, Section 27-501 (n)(2), please be aware that your claims history is considered in the company's decision to cancel or refuse to renew a policy.

PRODUCER COMPENSATION NOTICE

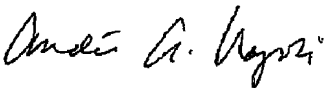
You can review and obtain information on The Hartford's producer compensation practices at www.TheHartford.com or at 1-800-592-5717.

POLICY NUMBER:

Our President and Secretary have signed this policy. Where required by law, the Information Page has been countersigned by our duly authorized representative.



Terence Shields, Secretary



André A. Napoli, President

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