



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

NJ TAX IDENTIFICATION NO.: 743062718000 NEW-14

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

1.

INSURED:

PREFERRED FREEZER SERVICES LLC  
1 MAIN STREET  
CHATHAM NJ 07928

PRODUCER:

LOCKTON COMPANIES LLC  
444 W 47TH STREET SUITE 900  
KANSAS CITY MO 64112

NCCI CO CODE: 13579

Insured is A LIMITED LIABILITY COMPANY

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

2. The policy period is from 03-01-14 to 03-01-15 12:01 A.M. at the insured's mailing address.

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

CA FL GA IL NJ PA TX VA

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

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

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

AL AR CO CT DC DE HI IA ID IN KS KY LA MD ME MI MN MO MS MT NC NE  
NH NM NV NY OK OR RI SC SD TN UT VT WV

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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



DATE OF ISSUE: 03-19-14 MP

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC

NA287



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POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION SCHEDULE:

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

SIC-CODE: 4222 NAICS: 493120

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	STANDARD
PREMIUM DISCOUNT		1744158
OTHER CHARGES & CREDITS		NONE
0900-12 EXPENSE CONSTANT		150
		280
TERRORISM		INCLUDED
CAT (OTHER THAN CERT ACTS OF TERRORISM)		INCLUDED
DEDUCTIBLE CREDIT		1183979
TOTAL ESTIMATED PREMIUM		560459
TAXES AND SURCHARGES		63674
DEPOSIT AMOUNT DUE		624133
		AMS BINDER BILLED #
		236572

Minimum Premium: \$ 1267

EMPLOYERS LIABILITY MINIMUM: \$ 150

OTHER MINIMUMS ARE INDICATED ON THE APPLICABLE SCHEDULE(S)

DATE OF ISSUE: 03-19-14 MP

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC NA287

COUNTERSIGNED-AGENT



ONE TOWER SQUARE  
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POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

050

13579-CA

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 521141

CLASSIFICATION

CODE

PREMIUM BASIS

ESTIMATED

TOTAL ANNUAL

REMUNERATION

RATES

PER \$100 OF

REMUNERATION

ESTIMATED

ANNUAL

PREMIUM

LOCATION 001 01

FEIN 141845714 ENTITY CD 002

PREFERRED FREEZER SERVICES OF  
LOS ANGELES LLC

3100 EAST WASHINGTON BLVD

LOS ANGELES, CA 90023

SIC CODE: 4222 NAICS: 493120

FEIN 204623879 ENTITY CD 003

PREFERRED FREEZER SERVICES LBF  
LLC

4901 BANDINI BLVD

VERNON, CA 90023

SIC CODE: 4222 NAICS: 493120

FEIN 141845714 ENTITY CD 004

PREFERRED FREEZER SERVICES OF  
VERNON LLC

2050 EAST 55TH STREET

VERNON, CA 90058

SIC CODE: 4222 NAICS: 493120

FEIN 043706482 ENTITY CD 005

PREFERRED FREEZER SERVICES  
ULTRAFREEZ LLC

2100 EAST 55TH STREET

VERNON, CA 90058

SIC CODE: 4222 NAICS: 493120

FEIN 743062719 ENTITY CD 006





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CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 743062719 ENTITY CD 006 (CONT'D)				
PREFERRED FREEZER SERVICES OF WILMINGTON LLC				
900 EAST M STREET WILMINGTON, CA 90744 SIC CODE: 4222 NAICS: 493120				
FEIN 205649989 ENTITY CD 007				
PREFERRED FREEZER SERVICES WASHINGTON BOULEVARD LLC				
3200 E WASHINGTON BLVD VERNON, CA 90023 SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 99 03 76 ( A ) WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	321860	.00	
WAREHOUSES-COLD STORAGE	8291	4945366	6.15	304140
WAREHOUSES-COLD STORAGE USL HW-SEE ENDT WC 99 01 01 MANRATE 6.1500	8291U	IF ANY	12.30	
SALESPERSONS-OUTSIDE	8742	IF ANY	.55	



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CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	4027218	.44	17720



CA MANUAL PREMIUM \$ 321860

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TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	\$	321860
ESTIMATED EXP MOD: 1.51 MODIFIED PREMIUM		486009
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		486009
DEDUCTIBLE CREDIT (9862)		333742
2.25% CIGA SURCHARGE		3426
2.23% USER / FRAUD / UEBT / SIBT / OSH / LEC		10838
TOTAL ESTIMATED PREMIUM		166531
DEPOSIT AMOUNT DUE		166531



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POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

15318-FL

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 911446030

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 141845708 ENTITY CD 008				
PREFERRED FREEZER SERVICES OF SOUTH FLORIDA LLC				
12855 NW 113TH STREET MIAMI, FL 33178 SIC CODE: 4222 NAICS: 493120				
FEIN 611437400 ENTITY CD 009				
PREFERRED FREEZER SERVICES OF MEDLEY LLC				
13700 NW 115TH STREET MEDLEY, FL 33178 SIC CODE: 4222 NAICS: 493120				
FEIN 205649917 ENTITY CD 010				
PREFERRED FREEZER SERVICES OF JACKSONVILLE LLC				
1780 WEST BEAVER STREET JACKSONVILLE, FL 32209 SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00) WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	187292	.03	5619
STORAGE WAREHOUSE-COLD	8291	2832906	6.34	179606



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CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.52	
CLERICAL OFFICE EMPLOYEES NOC	8810	2955977	.26	7686



FL MANUAL PREMIUM \$ 187292

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1.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 2622
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	195533
PRELIMINARY EXP MOD: .95 MODIFIED PREMIUM	185756
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	185756
DEDUCTIBLE CREDIT (9663)	118791
TOTAL ESTIMATED PREMIUM	66965
DEPOSIT AMOUNT DUE	66965



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POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-GA

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 911446030

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 205659504 ENTITY CD 027				
PREFERRED FREEZER OF ATLANTA LLC				
518 FOREST PARKWAY COLLEGE PARK, GA 30349 SIC CODE: 4222 NAICS: 493120				
315 WEST PONCE DE LEON AVE SUITE 833 DECATUR, GA 30030 SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00)				
WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	53880	.00	
STORAGE WAREHOUSE-COLD	8291	707035	7.24	51189
SALESPERSONS-OUTSIDE	8742	IF ANY	.55	



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CLASSIFICATION	CODE	PREMIUM BASIS		RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
		ESTIMATED TOTAL ANNUAL REMUNERATION	PER \$100 OF REMUNERATION		
LOCATION 001 01 (CONT'D)					
CLERICAL OFFICE EMPLOYEES NOC	8810	896947	.30	2691	

GA MANUAL PREMIUM \$ 53880

1.10% EMPL. LIAB. INCREASED LIMITS (9812)	\$ 593
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	54473
PRELIMINARY EXP MOD: .95 MODIFIED PREMIUM	51749
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	51749
DEDUCTIBLE CREDIT (9663)	31469
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE
TOTAL ESTIMATED PREMIUM	20280
DEPOSIT AMOUNT DUE	20280



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INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-IL

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 911446030

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 043720971 ENTITY CD 011				
PREFERRED FREEZER SERVICES OF CHICAGO LLC				
2500 SOUTH DAMEN AVENUE CHICAGO, IL 60608				
SIC CODE: 4222 NAICS: 493120				
FEIN 263100033 ENTITY CD 012				
PREFERRED FREEZER SERVICES OF CHICAGO II LLC				
4500 WEST ANN LURIE PLACE CHICAGO, IL 60632				
SIC CODE: 4222 NAICS: 493120				
FEIN 454735010 ENTITY CD 013				
PREFERRED FREEZER SERVICES OF CHICAGO III LLC				
6800 SANTA FE DRIVE BUILDING F HODGKINS, IL 60525				
SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00) WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	168212	.00	



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LOCATION 001 01 (CONT'D)				
STORAGE WAREHOUSE-COLD	8291	2728236	6.02	164240
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.42	
CLERICAL OFFICE EMPLOYEES NOC	8810	2090780	.19	3972



IL MANUAL PREMIUM \$ 168212

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1.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 2355
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	170567
PRELIMINARY EXP MOD: .95 MODIFIED PREMIUM	162039
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	162039
DEDUCTIBLE CREDIT (9663)	111272
EXPENSE CONSTANT (0900)	280
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE
1.01% IL IND COMM OP FUND SURCHARGE	1640
TOTAL ESTIMATED PREMIUM	52687
DEPOSIT AMOUNT DUE	52687



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INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-ND

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 743062718 ENTITY CD 001				
PREFERRED FREEZER SERVICES LLC				
NO BUSINESS LOCATION				
NONE, ND 58501				
SIC CODE: 4222 NAICS: 493120				
SALESPERSONS-OUTSIDE INCLUDED IN ** OTHER CHARGES	8742	IF ANY	.0220	150

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EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		NONE
** OTHER PREMIUM CHARGES		150
TOTAL ESTIMATED PREMIUM		150
DEPOSIT AMOUNT DUE		150



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INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NU

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 339595

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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LOCATION 001 01

FEIN 743062718 ENTITY CD 001  
NJ TAX IDENTIFICATION NO.: 743062718000  
PREFERRED FREEZER SERVICES LLC

1 MAIN STREET  
CHATHAM, NJ 07928  
SIC CODE: 4222 NAICS: 493120

200 POLAR WAY  
JERSEY CITY, NJ 07305  
SIC CODE: 4222 NAICS: 493120

FEIN 141845702 ENTITY CD 014  
NJ TAX IDENTIFICATION NO.: 141845702000  
PREFERRED FREEZER SERVICES OF  
JERSEY CITY LLC

100 POLAR WAY  
JERSEY CITY, NJ 07305  
SIC CODE: 4222 NAICS: 493120

FEIN 200291216 ENTITY CD 015  
NJ TAX IDENTIFICATION NO.: 200291216000  
PREFERRED FREEZER SERVICES OF  
NEWARK LLC

360 AVENUE P  
NEWARK, NJ 07105  
SIC CODE: 4222 NAICS: 493120

FEIN 141845706 ENTITY CD 016  
NJ TAX IDENTIFICATION NO.: 141845706000  
PREFERRED FREEZER SERVICES  
FFD LLC





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CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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LOCATION 001 01 (CONT'D)

FEIN 141845706 ENTITY CD 016 (CONT'D)

231 ELM STREET  
PERTH AMBOY, NJ 08861  
SIC CODE: 4222 NAICS: 493120

FEIN 141845704 ENTITY CD 017  
NJ TAX IDENTIFICATION NO.: 141845704000  
PREFERRED FREEZER SERVICES OF  
PERTH AMBOY LLC

536 FAYETTE  
PERTH AMBOY, NJ 08861  
SIC CODE: 4222 NAICS: 493120

FEIN 208800883 ENTITY CD 018  
NJ TAX IDENTIFICATION NO.: 208800883000  
PREFERRED FREEZER SERVICES OF  
ELIZABETH LLC

150 BAYWAY AVENUE  
ELIZABETH, NJ 07202  
SIC CODE: 4222 NAICS: 493120

FEIN 453303585 ENTITY CD 019  
NJ TAX IDENTIFICATION NO.: 453303585000  
PREFERRED FREEZER SERVICES OF  
LINDEN LLC

2710 ALLENN ST EXTENSION  
LINDEN, NJ 07036  
SIC CODE: 4222 NAICS: 493120

FEIN 743062717 ENTITY CD 020  
NJ TAX IDENTIFICATION NO.: 743062717000  
PREFERRED FREEZER SERVICES  
OPERATING LLC

1 MAIN STREET  
CHATHAM, NJ 07928  
SIC CODE: 4222 NAICS: 493120

FEIN 263914569 ENTITY CD 021  
NJ TAX IDENTIFICATION NO.: 263914569000



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LOCATION 001 01 (CONT'D)				
FEIN 263914569 ENTITY CD 021 (CONT'D)				
PREFERRED FREEZER SERVICES OF DAYTON LLC				
20 TOWER ROAD DAYTON, NJ 08810 SIC CODE: 4222 NAICS: 493120				
STORAGE WAREHOUSE-COLD	8291	6881491	12.19	838854
STORAGE WAREHOUSE-COLD	8291U	IF ANY	18.29	
SALESPERSONS-OUTSIDE	8742	1600165	.60	9601
CLERICAL OFFICE EMPLOYEES NOC	8810	8711924	.25	21780



NJ MANUAL PREMIUM \$ 870235

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1.40% EMPL. LIAB. INCREASED LIMITS (6199)	\$ 12183
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	882418
PRELIMINARY EXP MOD: .783 MODIFIED PREMIUM	\$ 690933
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	690933
DEDUCTIBLE CREDIT (9862)	474464
TERRORISM (9740)	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE
6.56% 0935 NJ SECOND INJURY FUND SURCHARGE	45325
TOTAL ESTIMATED PREMIUM	261794
TOTAL ESTIMATED COST	261794



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INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-0H

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 743062718	ENTITY CD 001			
PREFERRED FREEZER SERVICES LLC				
NO BUSINESS LOCATION				
NONE, OH 43085				
SIC CODE: 4222 NAICS: 493120				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	

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EXPERIENCE MODIFICATION: NONE	MODIFIED PREMIUM	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			NONE
TOTAL ESTIMATED PREMIUM			NONE
DEPOSIT AMOUNT DUE			NONE



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POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: THE PHOENIX INSURANCE COMPANY

12610-PA

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 3171536

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 203954812 ENTITY CD 022				
PREFERRED FREEZER SERVICES OF PHILADELPHIA LLC				
3101 SUOTH 3RD ST PHILADELPHIA, PA 19148 SIC CODE: 4222 NAICS: 493120				
WAREHOUSING	0813	967440	5.95	57563
BLANKET WAIVER SEE ENDT WC 00 03 13 (00) WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	59301	.00	
SALESPERSON-OUTSIDE	0951	IF ANY	.47	





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LOCATION 001 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES	0953	789879	.22	1738

PA MANUAL PREMIUM \$ 59301

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1.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 830
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	60131
EXPERIENCE MODIFICATION: 1.552 MODIFIED PREMIUM	93323
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	93323
DEDUCTIBLE CREDIT(9663)	64085
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE
2.62% PA EMPL ASSESSMENT (0938)	2445
TOTAL ESTIMATED PREMIUM	31683
DEPOSIT AMOUNT DUE	31683



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POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-TX

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 911446030

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 205650203 ENTITY CD 024				
PREFERRED FREEZER SERVICES OF HOUSTON PORT LLC				
10060 PORTER ROAD LA PORTE, TX 77571 SIC CODE: 4222 NAICS: 493120				
FEIN 205650162 ENTITY CD 025				
PREFERRED FREEZER SERVICES OF HOUSTON METRO LLC				
555 ALEEN STREET HOUSTON, TX 77029 SIC CODE: 4222 NAICS: 493120				
FEIN 462860957 ENTITY CD 026				
PREFERRED FREEZER SERVICES OF HOUSTON EXPRESS LLC				
7080 EXPRESS LANE HOUSTON, TX 77078 SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 42 03 04 ( A ) WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	45055	.02	901
WAREHOUSING-COLD STORAGE-& D	8292	1251933	3.44	43066





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LOCATION 001 01 (CONT'D)				
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	.24	
CLERICAL OFFICE EMPLOYEES NOC	8810	1325993	.15	1989

TX MANUAL PREMIUM \$ 45055

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2.00% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 901
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	46857
PRELIMINARY EXP MOD: .95 MODIFIED PREMIUM	44514
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	44514
66.88% DEDUCTIBLE CREDIT (9961)	29771
TOTAL ESTIMATED PREMIUM	14743
DEPOSIT AMOUNT DUE	14743



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-VA

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 911446030

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 205649401 ENTITY CD 023				
PREFERRED FREEZER SERVICES OF NORFOLK LLC				
2700 TRADE STREET CHESAPEAKE, VA 23323 SIC CODE: 4222 NAICS: 493120				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00)				
WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	30308	.02	606
STORAGE WAREHOUSE-COLD	8291	1050741	2.81	29526
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.20	





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	868815	.09	782

VA MANUAL PREMIUM \$ 30308

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1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 333
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	31247
PRELIMINARY EXP MOD: .95 MODIFIED PREMIUM	29685
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	29685
DEDUCTIBLE CREDIT(9663)	20385
TOTAL ESTIMATED PREMIUM	9300
DEPOSIT AMOUNT DUE	9300



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WA

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 743062718 ENTITY CD 001				
PREFERRED FREEZER SERVICES LLC				
NO BUSINESS LOCATION				
NONE, WA 98501				
SIC CODE: 4222 NAICS: 493120				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	



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EXPERIENCE MODIFICATION: NONE	MODIFIED PREMIUM \$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		NONE
TOTAL ESTIMATED PREMIUM		NONE
DEPOSIT AMOUNT DUE		NONE



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WY

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 743062718	ENTITY CD 001			
PREFERRED FREEZER SERVICES LLC				
NO BUSINESS LOCATION				
NONE, WY 82001				
SIC CODE: 4222 NAICS: 493120				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	

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EXPERIENCE MODIFICATION: NONE	MODIFIED PREMIUM	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			NONE
TOTAL ESTIMATED PREMIUM			NONE
DEPOSIT AMOUNT DUE			NONE



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 ( B )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

NJ TAX IDENTIFICATION NO.: 743062718000 NEW-14

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

1.

NCCI CO CODE: 13579

INSURED:

PREFERRED FREEZER SERVICES LLC  
1 MAIN STREET  
CHATHAM NJ 07928

PRODUCER:

LOCKTON COMPANIES LLC  
444 W 47TH STREET SUITE 900  
KANSAS CITY MO 64112

Insured is A LIMITED LIABILITY COMPANY

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

2. The policy period is from 03-01-14 to 03-01-15 12:01 A.M. at the insured's mailing address.

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

CA FL GA IL NJ PA TX VA

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

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

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

AL AR CO CT DC DE HI IA ID IN KS KY LA MD ME MI MN MO MS MT NC NE  
NH NM NV NY OK OR RI SC SD TN UT VT WV

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

See extension of info page.

DATE OF ISSUE: 03-19-14 MP

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC

NA287



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 ( B )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION SCHEDULE:

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

SIC-CODE: 4222 NAICS: 493120

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	STANDARD
PREMIUM DISCOUNT		1744158
OTHER CHARGES & CREDITS		NONE
0900-12 EXPENSE CONSTANT		150
		280
CAT (OTHER THAN CERT ACTS OF TERRORISM)		TERRORISM INCLUDED
DEDUCTIBLE CREDIT		INCLUDED
TOTAL ESTIMATED PREMIUM		1183979
TAXES AND SURCHARGES		560459
TOTAL ESTIMATED COST		63674
		624133
		AMS BINDER BILLED #
		236572

Minimum Premium: \$ 1267

DEPOSIT PREMIUM: \$ 624133

OTHER MINIMUMS ARE INDICATED ON THE APPLICABLE SCHEDULE(S)

DATE OF ISSUE: 03-19-14 MP

OFFICE: KANSAS CITY 095

PRODUCER: LOCKTON COMPANIES LLC NA287

COUNTERSIGNED-AGENT



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-NJ

INSURED'S NAME: PREFERRED FREEZER SERVICES LLC

RATE BUREAU ID: 339595

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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LOCATION 001 01

FEIN 743062718 ENTITY CD 001  
NJ TAX IDENTIFICATION NO.: 743062718000  
PREFERRED FREEZER SERVICES LLC

1 MAIN STREET  
CHATHAM, NJ 07928  
SIC CODE: 4222 NAICS: 493120

200 POLAR WAY  
JERSEY CITY, NJ 07305  
SIC CODE: 4222 NAICS: 493120

FEIN 141845702 ENTITY CD 014  
NJ TAX IDENTIFICATION NO.: 141845702000  
PREFERRED FREEZER SERVICES OF  
JERSEY CITY LLC

100 POLAR WAY  
JERSEY CITY, NJ 07305  
SIC CODE: 4222 NAICS: 493120

FEIN 200291216 ENTITY CD 015  
NJ TAX IDENTIFICATION NO.: 200291216000  
PREFERRED FREEZER SERVICES OF  
NEWARK LLC

360 AVENUE P  
NEWARK, NJ 07105  
SIC CODE: 4222 NAICS: 493120

FEIN 141845706 ENTITY CD 016  
NJ TAX IDENTIFICATION NO.: 141845706000  
PREFERRED FREEZER SERVICES  
FFD LLC





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 141845706 ENTITY CD 016 (CONT'D)				
231 ELM STREET				
PERTH AMBOY, NJ 08861				
SIC CODE: 4222 NAICS: 493120				
FEIN 141845704 ENTITY CD 017				
NJ TAX IDENTIFICATION NO.: 141845704000				
PREFERRED FREEZER SERVICES OF				
PERTH AMBOY LLC				
536 FAYETTE				
PERTH AMBOY, NJ 08861				
SIC CODE: 4222 NAICS: 493120				
FEIN 208800883 ENTITY CD 018				
NJ TAX IDENTIFICATION NO.: 208800883000				
PREFERRED FREEZER SERVICES OF				
ELIZABETH LLC				
150 BAYWAY AVENUE				
ELIZABETH, NJ 07202				
SIC CODE: 4222 NAICS: 493120				
FEIN 453303585 ENTITY CD 019				
NJ TAX IDENTIFICATION NO.: 453303585000				
PREFERRED FREEZER SERVICES OF				
LINDEN LLC				
2710 ALLENN ST EXTENSION				
LINDEN, NJ 07036				
SIC CODE: 4222 NAICS: 493120				
FEIN 743062717 ENTITY CD 020				
NJ TAX IDENTIFICATION NO.: 743062717000				
PREFERRED FREEZER SERVICES				
OPERATING LLC				
1 MAIN STREET				
CHATHAM, NJ 07928				
SIC CODE: 4222 NAICS: 493120				
FEIN 263914569 ENTITY CD 021				
NJ TAX IDENTIFICATION NO.: 263914569000				



ONE TOWER SQUARE  
HARTFORD, CT 06183

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 263914569 ENTITY CD 021 (CONT'D)				
PREFERRED FREEZER SERVICES OF DAYTON LLC				
20 TOWER ROAD DAYTON, NJ 08810 SIC CODE: 4222 NAICS: 493120				
STORAGE WAREHOUSE-COLD	8291	6881491	12.19	838854
STORAGE WAREHOUSE-COLD	8291U	IF ANY	18.29	
SALESPERSONS-OUTSIDE	8742	1600165	.60	9601



DATE OF ISSUE: 03-19-14 MP

092801

SCHEDULE NO: 3 OF MORE



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
CLERICAL OFFICE EMPLOYEES NOC	8810	8711924	.25	21780

NJ MANUAL PREMIUM \$ 870235

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1.40% EMPL. LIAB. INCREASED LIMITS (6199)	\$ 12183
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	882418
PRELIMINARY EXP MOD: .783 MODIFIED PREMIUM	690933
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	690933
DEDUCTIBLE CREDIT (9862)	474464
TERRORISM (9740)	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE
6.56% 0935 NJ SECOND INJURY FUND SURCHARGE	45325
TOTAL ESTIMATED PREMIUM	261794
TOTAL ESTIMATED COST	261794



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

LISTING OF ENDORSEMENTS  
EXTENSION OF INFO PAGE

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

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 B - 001	INFORMATION PAGE
WC 00 00 01 B - 001	INFORMATION PAGE 2
WC 00 00 01 B - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 04 03 17 00 - 001	ENDT AGRMNT LIMITING & RESTRICTING INS
WC 99 06 49 00 - 001	EMPLOYERS LIABILITY LIMITS OF LIABILITY
WC 29 06 01 A - 001	NJ LARGE RISK - LARGE DED ENDT
WC 99 06 E9 A - 001	WORKERS COMPENSATION DEDUCTIBLE ENDT
WC 99 06 G4 00 - 001	WORKERS COMPENSATION DEDUCTIBLE ENDT
WC 99 06 48 A - 001	WORK COMP LARGE DEDUCTIBLE ENDORSEMENT
WC 99 06 79 A - 001	WORKERS COMPENSATION DEDUCTIBLE ENDT
WC 00 01 06 A - 001	LONGSHORE AND HARBOR WC ACT COVERAGE
WC 00 01 14 00 - 001	PENDING LAW CHANGE TO TERRORISM RISK INS
WC 00 03 03 C - 001	EMPLOYERS LIAB COVERAGE ENDT
WC 00 03 11 A - 001	VOLUNTARY COMP AND EMPLOYERS LIAB COV
WC 00 03 11 00 - 001	VOL COMP AND EMP LIAB COV END
WC 00 03 13 00 - 001	WAIVER OF OUR RIGHT TO RECOVER
WC 00 04 03 00 - 001	EXPERIENCE RATING MODIFICATION FACTOR
WC 00 04 14 00 - 001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC 00 04 22 A - 001	TERRORISM-REAUTHORIZATION ACT DISCLOSURE
WC 42 01 01 00 - 001	TX PENDING LAW CHANGE TO TERRORISM RISK
WC 99 01 01 00 - 001	STATE WC COMP LAWS AND USL & H WC ACT
WC 99 03 C3 00 - 001	SPECIAL PROVISIONS ENDT
WC 99 03 D3 A - 001	OH EMPLOYERS LIAB COVERAGE ENDORSEMENT
WC 99 03 F3 00 - 001	CA LIMITS OF LIABILITY ENDT
WC 99 03 76 A - 001	WAIVER OF OUR RIGHTS TO RECOVER-CA
WC 99 03 97 00 - 001	WYOMING AMENDATORY ENDORSEMENT
WC 99 03 99 00 - 001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
WC 99 04 01 00 - 001	EXPERIENCE MODIFICATION - PRELIMINARY
WC 99 06 P7 00 - 001	NOTICE OF CANC OR NONRENEW BY US ENDT
WC 99 06 P8 00 - 001	FL NOTICE OF CANC OR NONRENEW BY US ENDT
WC 99 06 Q1 00 - 001	EARLIER NOTICE OF CAN OR NONRE BY US END
WC 99 06 10 A - 001	AMENDED CANCELLATION CONDITION ENDT.
WC 99 06 10 00 - 001	AMENDED CANCELLATION CONDITION
WC 99 06 11 00 - 001	NOTICE OF CANCELLATION
WC 99 06 36 A - 001	CANCELLATION AMENDMENT - WASHINGTON
WC 99 06 99 00 - 001	ND AMENDATORY ENDORSEMENT





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

LISTING OF ENDORSEMENTS  
EXTENSION OF INFO PAGE

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

W09N1I13	FL PENDING LAW CHANGE TO TERR RISK INS
WC 00 04 21 C - 001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT
WC 99 06 G2 B - 001	WC DEDUCTIBLE ENDORSEMENT
WC 99 06 G7 E - 001	FED TERRORISM RISK INS ACT DISCLOSURE
WC 99 01 19 A - 001	TERRORISM RISK INSURANCE PROGRAM ENDT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 04 01 01 A - 001	LONGSHORE & HARBOR WC ACT ENDT - CA
WC 04 03 01 B - 001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 04 03 05 00 - 001	VOL COMP & EMPLOYERS LIAB COV ENDT.
WC 04 03 60 A - 001	CA-EMPLOYERS LIAB COV AMENDATORY ENDT
WC 04 04 22 00 - 001	CALIFORNIA SHORT-RATE CANCELATION ENDT
WC 04 06 01 A - 001	CA CANCELATION ENDT
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 04 02 00 - 001	FLORIDA EXPERIENCE RATING MODIFICATION
WC 09 04 07 00 - 001	FL NON-COOPERATION WITH PREM AUDIT ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.
WC 10 04 02 00 - 001	GA NON-COOPERATION WITH PREM AUDIT ENDT
WC 10 06 01 A - 001	GA CANC NONRENEWAL AND CHG ENDT
WC 12 06 01 D - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 29 03 06 B - 001	NJ PART TWO EMPLOYERS LIABILITY ENDT.
WC 37 06 01 00 - 001	SPECIAL PA ENDT -- INSPECTION OF MANUALS
WC 37 06 02 00 - 001	NOTICE INS CONSULTATION SERVICE EXEMPT.
WC 37 06 03 A - 001	PA ACT 86-1986 ENDORSEMENT
WC 37 06 04 00 - 001	PA EMPLOYER ASSESSMENT ENDORSEMENT
WC 42 03 01 F - 001	TEXAS AMENDATORY ENDORSEMENT
WC 42 03 04 A - 001	TX WAIVER OF OUR RIGHT TO RECOVER
WC 42 04 07 00 - 001	TX AUDIT PREMIUM & RETRO PREM ENDT
WC 45 06 02 00 - 001	VA AMENDATORY ENDT
WC 99 06 J1 00 - 001	TEXAS AMENDATORY ENDT
WC 99 06 M2 00 - 001	FL TERR RISK INS REAUTH ACT-LG DED
WC 99 06 46 00 - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 99 06 47 00 - 001	AMENDED CANCELLATION CONDITION ENDT







ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 49 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## EMPLOYERS LIABILITY LIMITS OF LIABILITY ENDORSEMENT

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

1. The applicable limits of liability stated in Item 3.B. of the New Jersey Information Page WC 00 00 01 ( B ) and the limits of liability stated in the Countrywide Information Page WC 00 00 01 ( A ) of this policy refer to ONE AND THE SAME set of limits for Bodily Injury by Accident, Each Accident; Bodily Injury by Disease, Policy Limit; and Bodily Injury by Disease, Each Employee.
2. All other references to Part Two (Employers Liability Insurance) limits of liability within the policy remain unchanged.



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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 29 06 01 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## NEW JERSEY LARGE RISK - LARGE DEDUCTIBLE ENDORSEMENT

1. This endorsement applies to the insurance provided by:

Part One (Workers Compensation Insurance)  
Part Two (Employers Liability Insurance) and  
Part Three (Other States Insurance)

2. This endorsement applies between you and us. It does not affect the rights of others under the policy. Nor does it change our obligations under Part One, Part Two or Part Three of the policy, except as otherwise stated in this endorsement.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally, required, including allocated loss adjustment expense which arises out of any claim or suit we defend, where you elect to include such expense.
4. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amounts. The contract of insurance shall be fully enforceable by your employees or their dependents against us in accordance with NJSA 34:15-83.

### DEDUCTIBLE - EACH OCCURRENCE EACH CLAIM

5. The deductible amount stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined, including allocated loss adjustment expense if elected by you, for bodily injury to one or more employees as the result of any one accident or for disablement of one employee due to bodily injury by disease.

### DEDUCTIBLE - POLICY AGGREGATE

6. The amount stated in the Schedule as aggregate is the most you must reimburse us for the sum of all indemnity and medical benefits, damages, and allocated loss adjustment expense if elected by you, because of bodily injury by accident or bodily injury by disease for the policy period.
  - (a) If we cancel the policy, the aggregate amount stated in the Schedule will be reduced to a pro rata amount based on the time this policy was in force.
  - (b) If you cancel the policy as a result of your retiring from business, the aggregate deductible amount will be reduced to a pro rata amount based on the time this policy was in force.
  - (c) If you cancel the policy for any reason other than retiring from business, the aggregate deductible amount will not be reduced.
  - (d) If this policy is issued for a term of less than one year, the aggregate deductible amount will not be reduced.

### EFFECT OF DEDUCTIBLE ON LIMITS OF LIABILITY

7. The applicable limits of liability as respects Part Two (Employers Liability Insurance) are subject to reduction by the application of the loss reimbursement amount(s) applicable to any claim for accident or disease covered by this policy. In the event of a claim, our obligation to pay is the amount available for benefits or damages that remains after the application of the specific loss reimbursement amount. The payment of loss adjustment expense, where such expense is elected by you, will not affect the limits of liability.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 29 06 01 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**ALLOCATED LOSS ADJUSTMENT EXPENSE**

8. Allocated loss adjustment expense, which is electable by you, means claims expenses directly allocated by us to a particular claim. Such expense shall not include cost of investigation or the salaries and traveling expenses of our employees other than those salaried employees who perform services which can be directly allocated to the handling of a particular claim.

**RECOVERY FROM OTHERS**

9. If we recover any payments made under this policy from anyone liable for the injury, the amount we recover will be applied as follows:
  - (a) First, to any payments made by us in excess of the deductible amount and
  - (b) Then the remainder, if any, will be applied to reduce the deductible amount reimbursable by you.

**CANCELLATION**

10. If you fail to reimburse us for any amounts as required by this endorsement, we may cancel this policy for nonpayment in accordance with the provisions of statute. We will remain fully responsible for the full amount of all claims incurred prior to the effective date of cancellation.

**SOLE REPRESENTATION**

11. The first Named Insured stated in the Information Page will act on behalf of all the named insureds with respect to:
  - (a) Changes to this endorsement
  - (b) Obligations to receive premiums
  - (c) Giving or receiving notice of cancellation

**YOUR DUTIES AND UNDERSTANDINGS**

12. All bodily injuries by accident or disease for which you are responsible shall be promptly reported to us for adjustment and payment, regardless of their severity or cost. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

**OTHER RIGHTS AND DUTIES**

13. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
  - (a) Our right and duty to defend any claim, proceeding or suit against you and
  - (b) Your duties if injury occurs.

**ADDITIONAL CHARGES**

14. The surcharges for the Second Injury Fund and Uninsured Employers Fund and the premium charge for the expense constant are not part of the Large Risk - Large Deductible Program but are included in the total cost of the coverage provided by the policy to which this endorsement is attached.





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 29 06 01 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SCHEDULE**

<b>COVERAGE</b>		<b>DEDUCTIBLE AMOUNT BASIS</b>
Bodily Injury By Accident	\$ 250,000	each accident
Bodily Injury By Disease	\$ 250,000	each employee
All Covered Bodily Injury	\$ 0	aggregate



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 E9 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT

### A. General Conditions

1. This endorsement applies to the Workers Compensation Insurance, Employers Liability Insurance, and to the Other States Insurance coverage provided in this policy. This endorsement also applies to the insurance provided by any endorsement to this policy.
2. This endorsement applies between you and us. It does not affect the rights of others under the policy. Nor does it change our obligations under the policy except as otherwise stated in this endorsement.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally required, including Allocated Loss Adjustment Expense(s), where you have elected to include such expense as indicated in the Schedule, which arises out of any claim or suit we defend.
4. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amount, provided that this does not release you from your obligation to reimburse us.

### B. Deductible — Each Accident

1. The deductible amount - each accident stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined for bodily injury to one or more employees as the result of any one accident or for disablement of any one employee due to bodily injury by disease. All or a portion of the Allocated Loss Adjustment Expense may be included in the deductible amount depending upon the option selected by you, as indicated in the Schedule.

### C. Aggregate Deductible Limit

1. The amount stated in the Schedule as the Aggregate Deductible Limit is the most you must reimburse us for the sum of all indemnity and medical benefits and damages within the Each Accident Deductible. All or a portion of the Allocated Loss Adjustment Expense may be subject to the aggregate depending upon the option selected by you, as indicated in the Schedule.

The aggregate will not be reduced if:

- (a) this endorsement is issued for a term of less than (1) year, or
- (b) the policy or this endorsement is canceled for any reason by you or by us before the end of the policy period.

### D. Effect of Deductible on Employers Liability Limits

1. The applicable limits of liability as respects the Employers Liability insurance coverage provided in this policy will be reduced by the deductible amount(s) applicable to the corresponding type of Employers Liability claim for accident or disease covered under this policy. In the event of a claim, our liability to pay is the amount available for damages that remains after the subtraction of the specific deductible amount from the applicable limits of liability. The payment of Allocated Loss Adjustment Expense(s) will not reduce, and is in addition to, the limits of liability, but where elected by you, such expense will be reimbursed to us by you as stated in the Schedule.

### E. Allocated Loss Adjustment Expense

"Allocated Loss Adjustment Expense" (or "ALAE") encompasses the following costs of a carrier which can be directly allocated to a particular claim:



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1. Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representatives.
2. Court, Alternate Dispute Resolution and other specific items of expense whether incurred by an outside vendor or by one of our employees, including but not limited to:
  - Medical examinations of a claimant to determine the extent of our liability, degree of permanency or length of disability;
  - Expert medical or other testimony;
  - Autopsy;
  - Witnesses and summonses;
  - Copies of documents such as birth and death certificates and medical treatment records;
  - Arbitration fees;
  - Fees or costs for surveillance or other professional investigations which are conducted as part of the handling of a Claim;
  - Fees or costs for loss prevention and engineering personnel and fees or costs for rehabilitation nurses or other nurses, if the cost of such nurses is not included in losses, for services which are conducted as part of the handling of a Claim;
  - Appeal bond costs and appeal filing fees.
3. Medical cost containment expenses incurred with respect to a particular Claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include but are not limited to:
  - Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.
  - Hospital and other treatment utilization reviews, including precertification/pre-admission, concurrent or retrospective reviews.
  - Preferred provider Network/ Organization expenses.
  - Medical fee review panel expenses.
4. Expense(s) not defined as losses which are directly related to and directly allocated to the handling of a particular Claim and are required to be performed by statute or regulation.

The following shall not be included as "Allocated Loss Adjustment Expense":

1. Salaries, overhead and traveling expenses of carrier employees, except for employees while doing activities previously listed as allocated expenses.
2. Fees paid to independent Claims professionals or attorneys (hired to perform the function of Claim investigation normally performed by Claim adjusters) for developing and investigating a Claim so that a determination can be made of the cause, extent or responsibility for the injury, disease or damage, including evaluation and settlement of covered claims.
3. Expenses which are defined as either an indemnity or medical loss.

**F. Multiple Line/Multiple Policy Maximum Loss Content.**

1. As an alternative to an Aggregate Deductible Limit for Workers Compensation, you may agree to a Multiple Line/Multiple Policy Maximum Loss Content. Under this arrangement the maximum amount of payments by you for any reimbursement within a deductible, loss limit or retained limit for any policy listed



WORKERS COMPENSATION  
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in the schedule on the deductible endorsement, shall be limited to the amount specified as the Maximum Loss Content in that schedule.

The insured and insurer may agree to state the Maximum Loss Content as a negotiated rate per \$100 of final audited payroll, or other exposure base specified on the deductible endorsement, subject to a negotiated minimum aggregate.

As an alternative, the insured and insurer may also agree to state Maximum Loss Content as a negotiated percentage of final audited standard premium.

The Maximum Loss Content charge is the component intended to provide for the amount of loss (and ALAE, if applicable) expected to exceed the established Maximum Loss Content. If a Maximum Loss Content is selected, the aggregate deductible limit charge to be included in the Deductible Premium formula is negotiated by the insured and insurer.

**G. Recovery From Others**

1. If we recover any payments under this policy from anyone liable for the injury, the amount we recover will be applied as follows:
  - (a) First, to any payments made by us in excess of the deductible amount; and
  - (b) The remainder, if any, will be applied to reduce the deductible amount reimbursed by you.

**H. Sole Representation**

1. The first Named Insured stated in the Information Page will act on behalf of all the named insureds with respect to:
  - (a) Changes to this endorsement;
  - (b) Obligations to receive premiums; or
  - (c) Giving or receiving notice of cancellation.

**I. Your Duties and Understanding**

1. All bodily injuries by accident or disease for which you are responsible shall be promptly reported to us. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

**J. Other Rights and Duties**

1. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
  - (a) Our right and duty to defend any claim, proceeding or suit against you, and
  - (b) Your duties if injury occurs.





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 E9 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

SCHEDULE

1. Deductible Amount \$ 250,000 Each Accident (including disease as defined in Deductible – Each Accident).

2. Aggregate Limit is                   . It is adjusted based on: (option that applies is indicated by "X")

a.  Negotiated rate of                    per \$100 of  
(enter rate)

But in no event less than \$                   .  
(dollar amount)

b.  Negotiated percentage of standard premium                     
(Percentage of standard premium)

But in no event less than \$                   .  
(dollar amount)

c.  No Aggregate Limit applies.

3. Allocated Loss Adjustment Expenses (ALAE): (option that applies is indicated by "X")

A.  Included in the deductible – each accident limit and included in the aggregate amount; or

B.  Excluded from the deductible – each accident limit and                    aggregate amount; and  
(option that applies is indicated by "X") ("included in" or "excluded from")

i.  reimbursed by you for total amount of expense regardless of deductible limit(s); or

ii.  shared pro rata between you and us; or

iii.  fully paid by us in return for a flat charge payable by you  
flat charge:                     
(enter dollar amount)

4. Claims Handling and other associated expenses:

A. Claim Handling is (options that apply are indicated by "X")

i.  reimbursed by you as a percentage charge for each loss;  
percentage charge:                   ;

ii.  reimbursed by you as a flat charge for each claim;  
flat charge per claim \$ 175.00 CM, 1375.00 CB, 75.00 PER INCIDENT;

iii.  reimbursed by you as a flat charge against the policy;  
flat charge \$                   ;

B. Charges other than claim handling is: (option that applies is indicated by "X")

i.  reimbursed by you at a rate of 0.2090 times exposure base of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL  
per \$100 ; or

ii.  reimbursed by you as a flat charge of                    against the policy.



ONE TOWER SQUARE  
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ENDORSEMENT WC 99 06 E9 ( A )

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5. At final premium audit, this policy (option that applies is indicated by "X")

a.  will be billed to you at a rate of \$ 1.1191 per \$100 of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL

b.  will be billed to you using rates on Information Page.

6. Maximum Loss Content (Applicable only if 2.c. of this schedule is selected) (option that applies is indicated by "X")

a.  Negotiated rate of 6.8743 per \$100 of  
(enter rate)  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL

But in no event less than \$ 3,497,000,  
(dollar amount)

b.  Negotiated percentage of standard premium \_\_\_\_\_  
(Percentage of standard premium)

But in no event less than \$ \_\_\_\_\_,  
(dollar amount)

Schedule of Policy Numbers for which the Maximum Loss Content is applicable

TC2J-UB-1112L07-9-14  
TRK-UB-1112L43-6-14



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



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 G4 (OO)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT

### A. General Conditions

1. This endorsement applies to the Workers Compensation Insurance, Employers Liability Insurance, and to the Other States insurance coverage provided in this policy. This endorsement also applies to the insurance provided by any endorsement to this policy.
2. This endorsement applies between you and us. It does not affect the rights of others under the policy. Nor does it change our obligations under the policy except as otherwise stated in this endorsement. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amount, provided that this does not release you from your obligation to reimburse us.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally required under the policy, including Allocated Loss Adjustment Expense(s), where you have elected to include such expense as stated in the Schedule. You will also reimburse us for Claim Handling Expenses as set forth in the Schedule.

### B. Deductible – Each Accident

1. The deductible amount – each accident stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined for bodily injury to one or more employees as the result of any one accident or for any one employee due to bodily injury by disease. All or a portion of the Allocated Loss Adjustment Expense may be included in the deductible amount depending upon the option selected by you, as stated in the Schedule.

### C. Aggregate Deductible Limit

1. The amount stated in the Schedule as the aggregate deductible limit is the most you must reimburse us for the sum of all indemnity and medical benefits and damages within the Each Accident Deductible. All or a portion of the Allocated Loss Adjustment Expense may be included in the aggregate deductible limit depending upon the option selected by you, as stated in the Schedule.

We will not reduce the aggregate deductible limit if:

- (a) this endorsement is issued for a term of less than (1) year, or
- (b) the policy or this endorsement is canceled for any reason by you or by us before the end of the policy period.

### D. Effect of Deductible on Employers Liability Limits

1. The applicable limits of liability as respects the Employers Liability insurance coverage provided in this policy will be reduced by the deductible amount(s) applicable to the corresponding type of Employers Liability claim for accident or disease covered under this policy. In the event of a claim, our liability to pay is the amount available for damages that remains after the subtraction of the specific deductible amount from the applicable limits of liability. The payment of Allocated Loss Adjustment Expense(s), will not reduce, and is in addition to the limits of liability, but where elected by you, such expense will be reimbursed to us by you as stated in the Schedule.



WORKERS COMPENSATION  
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EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 G4 (OO)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**E. Allocated Loss Adjustment Expense**

1. Allocated Loss Adjustment Expense or ALAE shall encompass the following costs which can be directly allocated to a particular claim:
    - (1) Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representative.
    - (2) Court, Alternate Dispute Resolution and other specific items of expense such as:
      - (a) Medical examinations of a claimant to determine the extent of the carrier's liability, degree of permanency, or length of disability;
      - (b) Expert medical or other testimony;
      - (c) Autopsy;
      - (d) Witnesses and summonses;
      - (e) Copies of documents such as birth and death certificates, medical treatment records;
      - (f) Arbitration fees;
      - (g) Surveillance; and
      - (h) Appeal bond costs and appeal filing fees.
    - (3) Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include:
      - (a) Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.
      - (b) Hospital and Other Treatment Utilization Reviews, including precertification/preadmission, concurrent or retrospective reviews.
      - (c) Preferred Provider Network/Organization expenses
      - (d) Medical Fee Review Panel expenses.
    - (4) Expenses which are not defined as losses and are directly related to and directly allocated to the handling of a particular claim which are required to be performed by statute or regulation.
- The following shall not be included as Allocated Loss Adjustment Expense(s):
- (1) Salaries, overhead and traveling expenses of our employees, except for employees while doing activities previously listed as allocated expense.
  - (2) Fees paid to independent claims professionals or attorneys (hired to perform the function of claim investigations normally performed by claim adjusters) for developing and investigating a claim so that a determination can be made of the cause, extent or responsibility for the injury or disease, including evaluation and settlement of covered claims.
  - (3) Expenses which are defined as either an indemnity or medical loss.



WORKERS COMPENSATION  
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ENDORSEMENT WC 99 06 G4 (OO)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

2. If the option indicated on the schedule is for you to reimburse us for the total Allocated Loss Adjustment Expense with ALAE above the deductible limits being shared pro rata between you and us, your pro rata share of ALAE will be determined as follows:
  - (1) When ALAE is excluded from the deductible amount each accident and excluded from the aggregate deductible amount, we will calculate the ratio of the deductible amount each accident to the total loss. We will then multiply ALAE by that ratio to determine your pro rate share.
  - (2) When ALAE is excluded from the deductible amount each accident and included in the aggregate deductible amount, we will calculate the ratio of medical and indemnity loss within the aggregate deductible limit to the total medical and indemnity losses. We will then multiply ALAE by that ratio to determine your pro rata share.

**F. Recovery From Others**

1. If we recover any payments under this policy from anyone liable for the injury, the amount we recover will be applied as follows:
  - (a) First, to any payments made by us in excess of the deductible amount; and
  - (b) The remainder, if any, will be applied to reduce the deductible amount reimbursed by you.

**G. Cancellation**

1. If you fail to reimburse us for any amounts as required by this endorsement, or, if you fail to provide security in a form and amount acceptable to us, we may cancel this policy in accordance with the cancellation conditions. We will remain fully responsible for the full payment of all claims for bodily injury by accident or bodily injury by disease that occurred prior to the effective date of cancellation.

**H. Sole Representation**

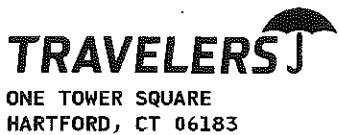
1. The insured first named in Item 1. of the Information Page will act on behalf of all the named insureds with respect to:
  - (a) Changes to this endorsement;
  - (b) Obligations to receive premiums; or
  - (c) Giving or receiving notice of cancellation.

**I. Your Duties and Understanding**

1. All bodily injury by accident or bodily injury by disease for which you are responsible shall be promptly reported to us. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

**J. Other Rights and Duties**

1. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
  - (a) Our right and duty to defend any claim, proceeding or suit against you, and
  - (b) Your duties if injury occurs.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 G4 (OO)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SCHEDULE**

1. Deductible Amount \$ 250,000 Each Accident (including disease as defined in Deductible – Each Accident).
2. Aggregate Deductible Limit Option (option that applies is indicated by "X")  
 Negotiated rate of \_\_\_\_\_ per \$100 of  
(enter rate)

But in no event less than \$ \_\_\_\_\_,  
(dollar amount)

Negotiated percentage of standard premium \_\_\_\_\_  
(Percentage of standard premium)

But in no event less than \$ \_\_\_\_\_,  
(dollar amount)

No Aggregate Deductible Limit applies.

3. Allocated Loss Adjustment Expenses (ALAE) (option that applies is indicated by "X")  
 Included in the deductible each accident limit and included in the aggregate amount; or  
 Excluded from the deductible each accident limit and \_\_\_\_\_ aggregate deductible amount;  
and (option that applies is indicated by "X") ("included in" or "excluded from")  
 reimbursed by you for total amount of expense regardless of deductible limit(s); or  
 reimbursed by you for total amount of expense; ALAE above the deductible limits will be shared pro  
rata between you and us; or  
 reimbursed by you as a flat charge against the policy, flat charge: \_\_\_\_\_;  
(enter dollar amount)
4. Claims Handling Expenses other than ALAE are (option that applies indicated by "X"):  
 reimbursed by you as a percentage charge for each loss;  
percentage charge: \_\_\_\_\_; or  
 reimbursed by you as a charge for each claim;  
charge per claim \$ 175.00 CM, 1375.00 CB, 75.00 PER INCIDENT; or  
 reimbursed by you as a flat charge against the policy;  
flat charge \$ \_\_\_\_\_;
5.  At final premium audit, this policy will be billed at a rate of \$ 1.1191 per \$100 of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL

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



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 48 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WORKERS COMPENSATION LARGE DEDUCTIBLE ENDORSEMENT

### A. General Conditions

1. This endorsement applies to the Workers Compensation Insurance, Employers Liability Insurance, and to the Other States Insurance coverage provided in this policy. This endorsement also applies to the insurance provided by any endorsement to this policy.
2. This endorsement applies between you and us. It does not affect the rights of others under the policy. Nor does it change our obligations under the policy except as otherwise stated in this endorsement.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally required, including Allocated Loss Adjustment Expense(s), where you have elected to include such expense as indicated in the Schedule, which arises out of any claim or suit we defend.
4. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amount, provided that this does not release you from your obligation to reimburse us.

### B. Deductible -- Each Accident

1. The deductible amount -- each accident stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined for bodily injury to one or more employees as the result of any one accident or for disablement of any one employee due to bodily injury by disease. All or a portion of the Allocated Loss Adjustment Expense may be included in the deductible amount depending upon the option selected by you, as indicated in the Schedule.

### C. Aggregate Deductible Limit

1. The amount stated in the Schedule as the Aggregate Deductible Limit is the most you must reimburse us for the sum of all indemnity and medical benefits and damages within the Each Accident Deductible. All or a portion of the Allocated Loss Adjustment Expense may be subject to the aggregate depending upon the option selected by you, as indicated in the Schedule.

The aggregate will not be reduced if:

- (a) this endorsement is issued for a term of less than (1) year, or
- (b) the policy or this endorsement is canceled for any reason by you or by us before the end of the policy period.

### D. Effect of Deductible on Employers Liability Limits

1. The applicable limits of liability as respects the Employers Liability insurance coverage provided in this policy will be reduced by the deductible amount(s) applicable to the corresponding type of Employers Liability claim for accident or disease covered under this policy. In the event of a claim, our liability to pay is the amount available for damages that remains after the subtraction of the specific deductible amount from the applicable limits of liability. The payment of Allocated Loss Adjustment Expense(s) will not reduce, and is in addition to, the limits of liability, but where elected by you, such expense will be reimbursed to us by you as stated in the Schedule.

### E. Allocated Loss Adjustment Expense

1. Allocated Loss Adjustment Expense (ALAE) encompasses the following costs which can be directly allocated to a particular claim:



WORKERS COMPENSATION  
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ENDORSEMENT WC 99 06 48 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

- (a) Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representatives.
  - (b) Court, Alternate Dispute Resolution and other specific items of expense whether incurred by an outside vendor or by one of our employees, including but not limited to:
    - Medical examinations of a claimant to determine the extent of our liability, degree of permanency, or length of disability;
    - Expert medical or other testimony;
    - Autopsy;
    - Witnesses and summonses;
    - Copies of documents such as birth and death certificates, medical treatment records;
    - Arbitration fees;
    - Fees or costs for surveillance or other professional investigations which are conducted as part of the handling of a Claim;
    - Fees or cost for loss prevention and engineering personnel and fees or cost for rehabilitation nurses or other nurses, if the cost of such nurses is not included in losses, for services which are conducted as part of the handling of a Claim;
    - Appeal bond costs and appeal filing fees.
  - (c) Medical cost containment expenses incurred with respect to a particular Claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include but are not limited to:
    - Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.
    - Hospital and other treatment utilization reviews, including precertification/pre-admission, concurrent or retrospective reviews.
    - Preferred Provider Network/ Organization expenses.
    - Medical Fee Review Panel expenses.
  - (d) Expenses which are not defined as losses and are directly related to and directly allocated to the handling of a particular Claim which are required to be performed by statute or regulation.
- The following shall not be included as "Allocated Loss Adjustment Expense":
- (1) Salaries, overhead and traveling expenses of carrier employees, except for employees while doing activities previously listed as allocated expense.
  - (2) Fees paid to independent Claims professionals or attorneys (hired to perform the function of Claim investigation normally performed by Claim adjusters) for developing and investigating a Claim so that a determination can be made of the cause, extent or responsibility for the injury, disease, or damage, including evaluation and settlement of covered Claims.
  - (3) Expenses which are defined as either an indemnity or medical loss.

**F. Multiple Line/Multiple Policy Maximum Loss Content.**

1. As an alternative to an Aggregate Deductible Limit for Workers Compensation, you may agree to a Multiple Line/Multiple Policy Maximum Loss Content. Under this arrangement the maximum amount of



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 48 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

payments by you for any reimbursement within a deductible, loss limit or retained limit for any policy listed in the Schedule on the deductible endorsement, shall be limited to the amount specified as the Maximum Loss Content in that schedule.

The insured and insurer may agree to state the Maximum Loss Content as a negotiated rate per \$100 of final audited payroll, or other exposure base specified on the Schedule of the deductible endorsement, subject to a negotiated minimum aggregate.

As an alternative, the insured and insurer may also agree to state Maximum Loss Content as a negotiated percentage of final audited Standard Premium.

The Maximum Loss Content charge is the charge which compensates us for the amount of loss (and ALAE, if applicable) expected to exceed the established Maximum Loss Content.

If a Maximum Loss Content is selected, the aggregate deductible limit charge to be included in the Deductible Premium is negotiated by the insured and insurer.

#### **G. Recovery From Others**

1. If we recover any payments under this policy from anyone liable for the injury, the amount we recover will be applied as follows:
  - (a) First, to any payments made by us in excess of the deductible amount; and
  - (b) The remainder, if any, will be applied to reduce the deductible amount reimbursed by you.

#### **H. Cancellation**

1. If you fail to reimburse us for any amounts as required by this endorsement, or, if you fail to provide security in a form and amount acceptable to us, we may cancel this policy in accordance with the cancellation conditions. We will remain fully responsible for the full payment of all claims for bodily injury by accident or bodily injury by disease that occurred prior to the effective date of cancellation, and you will remain fully responsible for reimbursing us.

#### **I. Sole Representation**

1. The first Named Insured stated in the Information Page will act on behalf of all the named insureds with respect to:
  - (a) Changes to this endorsement;
  - (b) Obligations to receive premiums; or
  - (c) Giving or receiving notice of cancellation.

#### **J. Your Duties and Understanding**

1. All bodily injuries by accident or disease for which you are responsible shall be promptly reported to us. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

#### **K. Other Rights and Duties**

1. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
  - (a) Our right and duty to defend any claim, proceeding or suit against you, and
  - (b) Your duties if injury occurs.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 48 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

SCHEDULE

1. Deductible Amount \$ 250,000 Each Accident (including disease as defined in Deductible – Each Accident).
2. Aggregate Limit is                   . It is adjusted based on: (option that applies is indicated by "X")
  - a.  Negotiated rate of                    per \$100 of  
(enter rate)

But in no event less than \$                     
(dollar amount)

- b.  Negotiated percentage of Standard Premium                     
(Percentage of Standard Premium)  
But in no event less than \$                     
(dollar amount)

- c.  No Aggregate Limit applies.

3. Allocated Loss Adjustment Expenses (ALAE): (option that applies is indicated by "X")
  - A.  Included in the deductible – each accident limit and included in the aggregate amount; or
  - B.  Excluded from the deductible – each accident limit and                    aggregate amount; and  
(option that applies is indicated by "X")
    - i.  reimbursed by you for total amount of expense regardless of deductible limit(s); or
    - ii.  shared pro rata between you and us; or
    - iii.  fully paid by us in return for a flat charge payable by you  
flat charge:                   ;  
(enter dollar amount)

4. Claims Handling and other associated expenses:

- A. Claim Handling is (options that apply are indicated by "X")
  - i.  reimbursed by you as a percentage charge for each loss;  
percentage charge:
  - ii.  reimbursed by you as a flat charge for each claim;  
flat charge per claim \$ 175.00 CM, 1375.00 CB, 75.00 PER INCIDENT;
  - iii.  reimbursed by you as a flat charge against the policy;  
flat charge \$                   .
- B. Charges other than Claim Handling are: (option that applies is indicated by "X")
  - i.  reimbursed by you at a rate of 0.2090 times exposure base of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL                    per \$100                   ; or
  - ii.  reimbursed by you as a flat charge of                    against the policy.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 48 (A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

5. At final premium audit, this policy (option that applies is indicated by "X")
  - a.  will be billed to you at a rate of \$ 1.1191 per \$100 of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL
  - b.  will be billed to you using rates on Information Page.
6. Maximum Loss Content (Applicable only if 2.c. of this schedule is selected) (option that applies is indicated by "X")
  - a.  Negotiated rate of 6.8743 per \$100 of  
(enter rate)  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL  
But in no event less than \$ 3,497,000.  
(dollar amount)
  - b.  Negotiated percentage of Standard Premium \_\_\_\_\_  
(Percentage of standard premium)  
But in no event less than \$ \_\_\_\_\_.  
(dollar amount)

Schedule of Policy Numbers for which the Maximum Loss Content is applicable

TC2J-UB-1112L07-9-14  
TRK-UB-1112L43-6-14

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



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 79 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT

1. This endorsement applies to the Workers' Compensation Insurance, Employers Liability Insurance and to the Other States Insurance coverage provided in this policy. This endorsement also applies to the insurance provided by any endorsement to this policy.
2. This endorsement applies between you and us. It does not change the rights of others under the policy. Nor does it change our obligations under the policy except as otherwise stated in this endorsement.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally required, including Allocated Loss Adjustment Expense(s), where you have elected to include such expense as indicated in the Schedule, which arises out of any claim or suit we defend.
4. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amount.

### Deductible – Each Accident

5. The deductible amount stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined for bodily injury to one or more employees as the result of any one accident or for disablement of any one employee due to bodily injury by disease. All or a portion of the Allocated Loss Adjustment Expense may be included in the deductible depending upon the option selected by you.

### Aggregate Deductible Limit

6. The amount stated in the Schedule as the aggregate deductible limit is the most you must reimburse us for the sum of all indemnity and medical benefits and damages within the Each Accident Deductible. All or a portion of the Allocated Loss Adjustment Expense may be subject to the aggregate depending upon the option selected by you, as indicated in the Schedule.

The aggregate will not be reduced if:

- (a) this endorsement is issued for a term of less than (1) year, or
- (b) the policy or this endorsement is cancelled for any reason by you or by us before the end of the policy period.

### Effect of Deductible on Limits of Liability

7. The applicable limits of liability as respects the Employers Liability insurance coverage provided in this policy are subject to reduction by the application of the loss reimbursement amount(s) applicable to any claim for accident or disease covered under this policy. In the event of a claim, our obligation to pay is the amount available for benefits or damages that remains after the application of the specific loss reimbursement amount. The payment of Allocated Loss Adjustment Expense(s), where such expense is elected by you, will not reduce, and is in addition to the limits of liability.

### Allocated Loss Adjustment Expense

8. Allocated Loss Adjustment Expense shall encompass the following costs which can be directly allocated to a particular claim:
  - (1) Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representative.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 79 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**(2) Court, Alternate Dispute Resolution and other specific items of expense, such as:**

Medical examinations of a claimant to determine the extent of the carrier's liability, degree of permanency, or length of disability;

Expert medical or other testimony;

Autopsy;

Witnesses, and summonses;

Copies of documents such as birth and death certificates, medical treatment records;

Arbitration fees;

Surveillance;

Appeal bond costs and appeal filing fees.

**(3) Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include:**

Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.

Hospital and Other Treatment Utilization Reviews, including precertification/preadmission, concurrent or retrospective reviews.

Preferred Provider Network/Organization expenses.

Medical Fee Review Panel expenses.

**(4) Expenses which are not defined as losses and are directly related to and directly allocated to the handling of a particular claim which are required to be performed by statute or regulation.**

The following shall not be included as Allocated Loss Adjustment Expense(s):

**(1) Salaries, overhead and traveling expenses of our employees, except for employees while doing activities previously listed as allocated expense.**

**(2) Fees paid to independent claims professionals or attorneys (hired to perform the function of claim investigations normally performed by claim adjusters) for developing and investigating a claim so that a determination can be made of the cause, extent or responsibility for the injury or disease, including evaluation and settlement of covered claims.**

**(3) Expenses which are defined as either an indemnity or medical loss.**

**Recovery From Others**

**9. If we recover any payments under this policy from anyone liable for the injury, the amount we recover will be applied as follows:**

**(a) First, to any payments made by us in excess of the deductible amount; and**

**(b) The remainder, if any, will be applied to reduce the deductible amount reimbursable by you.**



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 79 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**Cancellation**

10. If you fail to reimburse us for any amounts as required by this endorsement, or, if you fail to provide security in a form and amount acceptable to us, we may cancel this policy in accordance with the cancellation conditions. We will remain fully responsible for the full amount of all claims incurred prior to the effective date of cancellation.

**Sole Representation**

11. The first Named Insured stated in the Information Page will act on behalf of all the named insureds with respect to:
- (a) Changes to this endorsement;
  - (b) Obligations to receive premiums; or
  - (c) Giving or receiving notice of cancellation.

**Your duties and Understanding**

12. All bodily injuries by accident or disease for which you are responsible shall be promptly reported to us. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

**Other Rights and Duties**

13. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
- (a) Our right and duty to defend any claim, proceeding or suit against you, and
  - (b) Your duties if injury occurs.





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 79 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)  
SCHEDULE

1. Deductible Amount \$250,000 Each Accident

2. Aggregate Limit is (check one)

Negotiated rate of \_\_\_\_\_ per \$100 of  
(enter rate)

But in no event less than \$ \_\_\_\_\_.  
(dollar amount)

Negotiated percentage of standard premium \_\_\_\_\_.  
(Percentage of  
standard premium)

But in no event less than \$ \_\_\_\_\_.  
(dollar amount)

No Aggregate Limit applies.

3. Allocated Loss Adjustment Expenses (ALAE):

- Included in the deductible limit and included in the aggregate amount; or  
 Excluded from the deductible limit and \_\_\_\_\_ aggregate amount; and  
("Included in" or "excluded from")  
 Reimbursed by insured for total amount of expense regardless of deductible limit(s); or  
 Reimbursed by insured for total amount of expense; ALAE above the deductible limits will be  
shared pro rata between insured and insurer; or  
 Reimbursed fully by insurer in return for a flat charge

flat charge: \_\_\_\_\_; or  
(enter dollar amount)

4. Claims Handling Expenses other than ALAE are:

- Reimbursed by the insured as a percentage charge for each loss;  
percentage charge: \_\_\_\_\_; or  
 Reimbursed by the insured as a flat charge for each claim;  
flat charge per claim \$ 175.00 CM, 1375.00 CB, 75.00 PER INCIDENT; or  
 Reimbursed by the insured as a flat charge against the policy;

5. flat charge \$ \_\_\_\_\_.

At final premium audit, this policy

will be billed at a rate of \$ 1,1191 per \$100 of  
AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC  
STATES PAYROLL

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



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 01 06 ( A ) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT  
COVERAGE ENDORSEMENT**

This endorsement applies only to work subject to the Longshore and Harbor Workers' Compensation Act in a state shown in the Schedule. The policy applies to that work as though that state were listed in Item 3.A. of the Information Page. General Section C. Workers' Compensation Law is replaced by the following:

**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 and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Longshore and Harbor Workers' Compensation Act.

This endorsement does not apply to work subject to the Defense Base Act, the Outer Continental Shelf Lands Act, or the Nonappropriated Fund Instrumentalities Act.

The rates for classifications with code numbers not followed by the letter "F" are rates for work not ordinarily subject to the Longshore and Harbor Workers' Compensation Act. If this policy covers work under such classifications, and if the work is subject to the Longshore and Harbor Workers' Compensation Act, those non-F classification rates will be increased by the Longshore and Harbor Workers' Compensation Act Coverage Percentage shown in the Schedule.

**SCHEDULE**

State	Longshore and Harbor Workers' Compensation Act Coverage Percentage
FL	121 .00
GA	47 .00
IL	38 .00
ND	76 .00
NJ	50 .00
OH	155 .00
PA	78 .10
TX	64 .00
VA	69 .00
WA	101 .00



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

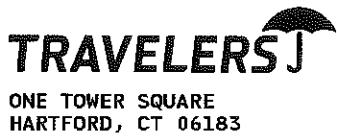
ENDORSEMENT WC 00 01 06 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SCHEDULE**

STATE  
WY

LONGSHORE AND HARBOR WORKERS'  
COMPENSATION ACT COVERAGE PERCENTAGE  
161 .00



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 00 01 14 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

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

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

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

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

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

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

You need not do anything further at this time.



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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium:

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14

ST ASSIGN:

Page 1 of 1

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WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 00 03 03 (C)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

- A. Part One (Workers Compensation Insurance) does not apply to work in a state shown in the Schedule.
- B. Part Two (Employers Liability Insurance) applies to work in states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.
- C. Part Two (Employers Liability Insurance), C. Exclusions is changed by adding these exclusions.

This insurance does not cover:

- 13. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of any state shown in the Schedule or otherwise fail to comply with that law.

### SCHEDULE

#### States

ND WA WY

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (A) -

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE  
ENDORSEMENT**

This endorsement adds Voluntary Compensation Insurance to the policy.

**A. How This Insurance Applies**

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

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

**B. We Will Pay**

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

**C. Exclusions**

This insurance does not cover:

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

**D. Before We Pay**

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

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

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

**E. Recovery From Others**

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (A) -

POLICY NUMBER: (TC2JUB-1112L07-9-14)

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 EMPLOYEES NOT SUBJECT TO THE WORKERS' COMPENSATION LAW	ALL STATES EXCEPT CA NJ ND OH TX WA AND WY	STATE OF HIRE



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (00) -

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**VOLUNTARY COMPENSATION AND  
EMPLOYERS LIABILITY COVERAGE ENDORSEMENT**

This endorsement adds Voluntary Compensation Insurance to the policy.

**A. HOW THIS INSURANCE APPLIES**

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

1. The bodily injury must be sustained by an employee included in the group of employees described in the Schedule.
2. The bodily injury must occur 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.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (00) —

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**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**

1. EMPLOYEES	STATE OF EMPLOYMENT	DESIGNATED WORKERS COMPENSATION LAW
ALL EMPLOYEES NOT SUBJECT TO THE WORKERS' COMPENSATION LAW	TX	STATE OF HIRE



ONE TOWER SQUARE  
HARTFORD, CT 06183

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 03 13 (00)-01

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT**

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

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

## SCHEDULE

**DESIGNATED PERSON:**



**DESIGNATED ORGANIZATION:**

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

DATE OF ISSUE: 03-19-14

**ST ASSIGN:**



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 00 04 03 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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.



ONE TOWER SQUARE  
HARTFORD, CT 06183

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## **NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT**

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

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



DATE OF ISSUE: 03-19-14

**ST ASSIGN:**

002820



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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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

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

### Definitions

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

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

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

- The act is an act of terrorism.
- The act is violent or dangerous to human life, property or infrastructure.
- 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.

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

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

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

### Limitation of Liability

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



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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**Policyholder Disclosure Notice**

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

**Schedule**

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



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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14

ST ASSIGN:

Page 2 of 2



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 42 01 01 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

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

This endorsement is being sent to you with respect to your workers compensation and employers liability insurance policy.

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

Since the timetable for any further Congressional action respecting TRIPRA is unknown at this time, and exposure to acts of terrorism remains, we are providing our policyholders with relevant information concerning their workers compensation policies in effect on or after January 1, 2014 in the event of TRIPRA's expiration. Your policy provides coverage for workers compensation losses caused by acts of terrorism or war, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy.

**The premium charge for the coverage your policy provides for terrorism or war losses may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2014 in the event of TRIPRA's expiration, subject to regulatory review in accordance with applicable state law.**



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 01 (00) - 001

POLICY NUMBER: (TC2JUB~1112L07-9-14)

**OPERATIONS INVOLVING BOTH STATE WORKERS  
COMPENSATION LAWS AND THE U. S. LONGSHOREMEN'S  
AND HARBOR WORKERS' COMPENSATION ACT**

You agree to keep your payroll records split between the remuneration earned by your employees while working on the shore and the remuneration earned while working upon the Navigable Waters of the United States, including any dry dock.

Your operation shall be assigned to the proper classification and the rates that we apply for such Non-F classification will be increased, according to manual rule, by the following percentages:

STATE	PERCENTAGE	STATE	PERCENTAGE
CA	100.00	FL	121.00
GA	47.00	IL	138.00
ND	76.00	NJ	100.00
OH	155.00	PA	78.10
TX	64.00	VA	69.00
WA	101.00	WY	161.00



DATE OF ISSUE: 03-19-14 ST ASSIGN:

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WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 03 C3 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SPECIAL PROVISIONS ENDORSEMENT  
STATE APPLICABILITY**

The listed endorsements are only applicable in the following states:

WC 00 01 06 ( A )-001 LONGSHORE AND HARBOR WC ACT COV ENDORSEMENT  
APPLIES TO STATE(S): FL GA IL NJ PA TX VA  
WC 00 01 14 ( 00 )-001 CW NOTIFICATION ENDT OF PENDING LAW CHG TO TERRORI  
APPLIES TO STATE(S): CA GA IL NJ PA VA  
WC 00 03 03 ( C )-001 CW EMPLOYERS LIABILITY COVERAGE ENDORSEMENT  
APPLIES TO STATE(S): GA IL NJ PA TX VA  
WC 00 03 11 ( A )-001 VOLUNTARY COMP AND EMPLOYERS LIAB COV ENDT  
APPLIES TO STATE(S): FL GA IL PA VA  
WC 00 03 11 ( 00 )-001 VOL COMP AND EMP LIAB COV END  
APPLIES TO STATE(S): TX  
WC 00 03 13 ( 00 )-001 WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS  
APPLIES TO STATE(S): FL GA IL PA VA  
WC 00 04 03 ( 00 )-001 EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT  
APPLIES TO STATE(S): GA IL NJ PA VA  
WC 00 04 14 ( 00 )-001 NOTIFICATION OF CHANGE IN OWNERSHIP ENDT  
APPLIES TO STATE(S): FL GA IL VA  
WC 00 04 19 ( 00 )-001 MULTI-STATE PREMIUM DUE DATE ENDORSEMENT  
APPLIES TO STATE(S): FL GA IL NJ PA VA  
WC 00 04 21 ( C )-001 CATASTROPHE ( OTHER THAN CERT ACTS OF TERRORISM ) PR  
APPLIES TO STATE(S): CA GA IL NJ PA  
WC 00 04 22 ( A )-001 Terrorism-Reauthorization Act Disclosure  
APPLIES TO STATE(S): CA GA IL NJ PA TX VA  
WC 04 01 01 ( A )-001 LONGSHOREMEN'S & HARBOR WKRS' COMP ACT COV END-CA  
APPLIES TO STATE(S): CA  
WC 04 03 01 ( B )-001 CA POLICY AMENDATORY ENDORSEMENT-CALIFORNIA  
APPLIES TO STATE(S): CA  
WC 04 03 05 ( 00 )-001 VOL COMP & EMPLOYERS LIAB COV ENDORSEMENT-CA  
APPLIES TO STATE(S): CA  
WC 04 03 17 ( 00 )-001 CA ENDORSEMENT AGREEMENT LIMITING AND RESTRICG  
APPLIES TO STATE(S): CA

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 03 C3 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SPECIAL PROVISIONS ENDORSEMENT  
STATE APPLICABILITY**

The listed endorsements are only applicable in the following states:

WC 04 03 60 ( A)-001 CA EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDT  
APPLIES TO STATE(S): CA  
WC 04 04 22 (00)-001 CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT  
APPLIES TO STATE(S): CA  
WC 04 06 01 ( A)-001 CA CANCELATION ENDT  
APPLIES TO STATE(S): CA  
WC 09 03 03 (00)-001 FL EMPLOYERS LIABILITY COVERAGE ENDORSEMENT  
APPLIES TO STATE(S): FL  
WC 09 04 02 (00)-001 FLORIDA EXPERIENCE RATING MODIFICATION FTR ENDT  
APPLIES TO STATE(S): FL  
WC 09 04 07 (00)-001 FLORIDA NON-COOPERATION WITH PREMIUM AUDIT  
APPLIES TO STATE(S): FL  
WC 09 06 06 (00)-001 FL EMPLOYMENT AND WAGE INFORMATION REL. ENDT.  
APPLIES TO STATE(S): FL  
WC 10 04 02 (00)-001 GA NON-COOPERATION WITH PREMIUM AUDIT ENDT  
APPLIES TO STATE(S): GA  
WC 10 06 01 ( A)-001 GA CANC NONRENEWAL AND CHG ENDT  
APPLIES TO STATE(S): GA  
WC 12 06 01 ( D)-001 IL ILLINOIS AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S): IL  
WC 29 03 06 ( B)-001 NEW JERSEY PART TWO EMPRS LIABILITY ENDT  
APPLIES TO STATE(S): NJ  
WC 29 06 01 ( A)-001 NJ LARGE RISK - LARGE DED ENDT  
APPLIES TO STATE(S): NJ  
WC 37 06 01 (00)-001 SPECIAL PA ENDORSEMENT -- INSPECTION OF MANUALS  
APPLIES TO STATE(S): PA  
WC 37 06 02 (00)-001 NOTICE INS CONSULTATION SERVICE EXEMPTION ACT  
APPLIES TO STATE(S): PA  
WC 37 06 03 ( A)-001 PENNSYLVANIA ACT 86-1986 ENDORSEMENT  
APPLIES TO STATE(S): PA  
WC 37 06 04 (00)-001 PA EMPLOYER ASSESSMENT ENDORSEMENT  
APPLIES TO STATE(S): PA  
WC 42 01 01 (00)-001 TEXAS NOTIFICATION ENDORSEMENT OF PENDING LAW  
APPLIES TO STATE(S): TX  
WC 42 03 01 ( F)-001 TX AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S): TX  
WC 42 03 04 ( A)-001 TX WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS  
APPLIES TO STATE(S): TX  
WC 42 04 07 (00)-001 TX AUDIT PREMIUM AND RETROSPECTIVE PREMIUM  
APPLIES TO STATE(S): TX  
WC 45 06 02 (00)-001 VA AMENDATORY ENDT



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 03 C3 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SPECIAL PROVISIONS ENDORSEMENT  
STATE APPLICABILITY**

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S): VA  
WC 99 01 01 (00)-001 STATE WC COMP LAWS AND USL & H WC ACT  
APPLIES TO STATE(S): CA FL GA IL PA VA  
WC 99 01 19 ( A)-001 TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION  
APPLIES TO STATE(S):  
WC 99 03 C3 (00)-001 CA SPECIAL PROVISIONS ENDORSEMENT  
APPLIES TO STATE(S): CA  
WC 99 03 D3 ( A)-001 OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT  
APPLIES TO STATE(S):  
WC 99 03 F3 (00)-001 CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT  
APPLIES TO STATE(S): CA  
WC 99 03 76 ( A)-001 WAIVER TO RECOVER ENDT - CA  
APPLIES TO STATE(S): CA  
WC 99 03 97 (00)-001 WYOMING AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S):  
WC 99 03 99 (00)-001 CA NOTICE OF NON-RENEWAL  
APPLIES TO STATE(S): CA  
WC 99 04 01 (00)-001 EXPERIENCE MODIFICATION - PRELIMINARY  
APPLIES TO STATE(S): GA PA VA  
WC 99 06 E9 ( A)-001 WORKERS COMPENSATION LARGE DEDUCTIBLE ENDORSEMENT  
APPLIES TO STATE(S): PA  
WC 99 06 G2 ( B)-001 WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT  
APPLIES TO STATE(S): FL  
WC 99 06 G4 (00)-001 VA WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT  
APPLIES TO STATE(S): VA  
WC 99 06 G7 ( E)-001 FEDERAL TERRORISM RISK INSURANCE ACT DISCLOSURE  
APPLIES TO STATE(S): CA GA IL PA TX VA  
WC 99 06 J1 (00)-001 TEXAS AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S): TX  
WC 99 06 M2 (00)-001 FLORIDA TERRORISM RISK INSURANCE PROGRAM  
APPLIES TO STATE(S): FL  
WC 99 06 P7 (00)-001 NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSE  
APPLIES TO STATE(S): CA  
WC 99 06 P8 (00)-001 FLORIDA NOTICE OF CANCELLATION OR NONRENEWAL BY US  
APPLIES TO STATE(S): FL  
WC 99 06 Q1 (00)-001 EARLIER NOTICE OF CANCELLATION OR NONRENEWAL BY US  
APPLIES TO STATE(S): IL PA TX  
WC 99 06 10 ( A)-001 AMENDED CANCELLATION CONDITION  
APPLIES TO STATE(S): GA  
WC 99 06 10 (00)-001 AMENDED CANCELLATION CONDITION  
APPLIES TO STATE(S): VA



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
PERMITMENT WC 99 03 C3 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SPECIAL PROVISIONS ENDORSEMENT  
STATE APPLICABILITY**

The listed endorsements are only applicable in the following states:

WC 99 06 11 (00)-001 NOTICE OF CANCELLATION  
APPLIES TO STATE(S): NJ PA  
WC 99 06 36 ( A)-001 CANCELLATION AMENDMENT - WASHINGTON  
APPLIES TO STATE(S):  
WC 99 06 46 (00)-001 ILLINOIS AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S): IL  
WC 99 06 47 (00)-001 CW AMENDED CANCELLATION CONDITION ENDORSEMENT  
APPLIES TO STATE(S):  
WC 99 06 48 (A )-001 WORKERS COMPENSATION LARGE DEDUCTIBLE ENDORSEMENT  
APPLIES TO STATE(S): CA GA IL  
WC 99 06 49 (00)-001 NJ EMPLOYERS LIABILITY LIMITS OF LIABILITY ENDORSE  
APPLIES TO STATE(S): NJ  
WC 99 06 79 (A )-001 WORKERS COMPENSATION LARGE DED. ENDORSEMENT  
APPLIES TO STATE(S): TX  
WC 99 06 99 (00)-001 ND AMENDATORY ENDORSEMENT  
APPLIES TO STATE(S):



DATE OF ISSUE: 03-19-14

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 03 D3 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT**

This endorsement applies only to work in Ohio.

- A. Part One (Workers Compensation Insurance) does not apply to work in Ohio.
- B. Part Two (Employers Liability Insurance) applies to work in Ohio as though it were shown in Item 3.A. of the Information Page.
- C. Part Two (Employers Liability Insurance), C. Exclusions 5. is removed and replaced with the following:

**C. Exclusions**

This insurance does not cover:

- 5. bodily injury directly intended by the insured;

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

- 14. bodily injury to an employee when you are deprived by common law defense or are subject to penalty because of your failure to secure your obligations under the workers compensation law of Ohio or otherwise fail to comply with the law.



ONE TOWER SQUARE  
HARTFORD, CT 06183

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT

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

The limits of our liability under Part Two of the policy are:

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

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



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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 76 ( A ) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS  
ENDORSEMENT – CALIFORNIA  
(BLANKET WAIVER)**

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule.

The additional premium for this endorsement shall be 0 .00 % of the California workers' compensation premium.

**Schedule**

**Person or Organization**

**Job Description**

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

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 97 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WYOMING AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the Employers Liability Coverage Endorsement for work in the state of Wyoming.

Part One (Workers Compensation Insurance) does not apply to work in Wyoming.

### PART TWO – EMPLOYERS LIABILITY INSURANCE

D. **We Will Defend** is amended by addition of the following:

The tender of policy limits before judgment or settlement does not relieve us of the duty to defend.

### PART SIX – CONDITIONS

D. **Cancelation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. If 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 cancelation 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 cancelation at least 10 days before the cancelation is to take effect. If we cancel for any other reason, except a material misrepresentation of fact, we will mail the notice of cancelation not less than 45 days before the cancelation is to take effect. Our notice will state the reasons for cancelation.

#### 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 of anniversary date of the policy. Our notice of nonrenewal will state the reasons for nonrenewal.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 99 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**CALIFORNIA WORKERS' COMPENSATION  
NOTICE OF NON-RENEWAL**

Section 11664 of the California Insurance Code which becomes operative November 30, 1994 requires us in most instances to provide you with a notice of non-renewal. Except as specified in paragraphs 1 through 6 below, if we elect to non-renew your policy, we are required to deliver or mail to you a written notice stating the reason or reasons for the non-renewal of the policy. The notice is required to be sent to you no earlier than 120 days before the end of the policy period and no later than 30 days before the end of the policy period. If we fail to provide you the required notice, we are required to continue the coverage under the policy with no change in the premium rate until 60 days after we provide you with the required notice.

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.
3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.
4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.
6. We made a written offer to you at least 30 days, but not more than 120 days, prior to the end of the policy period to renew the policy at a changed premium rate.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 04 01 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**EXPERIENCE MODIFICATION – PRELIMINARY**

We agree that the experience modification shown in this policy is preliminary. When all applicable pending state rate filings have been approved, the experience modification, shall be adjusted and when approved by the rating authorities having jurisdiction, the approved experience modification will be added to your policy by endorsement.



DATE OF ISSUE: 03-19-14

ST ASSIGN:

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 P7 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

The following replaces **PART SIX – CONDITIONS, D. Cancellation**, Paragraph 2.:

2. We may cancel or not renew this policy by mailing or delivering to you written notice stating when such cancellation or nonrenewal 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. We will mail or deliver that notice:
  - a. At least ten days before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for nonpayment of premium; or
  - b. At least the number of days shown in the Schedule before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for any other reason.

Notwithstanding the provisions above, in no event will the number of days advance notice for cancellation or nonrenewal be fewer than the number of days notice required by applicable law.

### SCHEDULE

NUMBER OF DAYS 90

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14 ST ASSIGN:

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 P8 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**FLORIDA NOTICE OF CANCELLATION OR NONRENEWAL BY US  
ENDORSEMENT**

The following replaces PART SIX – CONDITIONS, D. Cancellation, Paragraph 2.:

2. We may cancel or not renew this policy by mailing or delivering to you written notice stating when such cancellation or nonrenewal 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. We will mail or deliver that notice:
    - a. At least ten days before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for nonpayment of premium; or
    - b. At least the number of days shown in the Schedule before the effective date of the cancellation or non-renewal, if we cancel or do not renew for any other reason.

Notwithstanding the provisions above, in no event will the number of days advance notice for cancellation or nonrenewal for any reason other than nonpayment of premium be fewer than the 45 days notice required by Florida law.

## SCHEDULE

NUMBER OF DAYS 90



All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

## Insurance Company

Countersigned by

DATE OF ISSUE: 03-19-14 ST ASSIGN:

Page 1 of 1

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 Q1 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## EARLIER NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

The following modifies the **Cancellation** condition in **PART SIX – CONDITIONS** or in any endorsement forming a part of this policy that amends such condition:

If we cancel or do not renew this policy for any reason other than nonpayment of premium, we will increase the number of days advance notice for cancellation or nonrenewal from the number of days required by applicable law to the number of days shown in the Schedule.

### SCHEDULE

NUMBER OF DAYS 90

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14 ST ASSIGN:

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ONE TOWER SQUARE  
HARTFORD, CT 06183

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 06 10 (A)**

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## AMENDED CANCELLATION CONDITION ENDORSEMENT

We agree that Part Six, D. Cancellation, item 2 of the policy, is amended as follows:

We may cancel or nonrenew this policy by mailing or delivering to you at the address shown on the Information Page written notice stating when A) not less than ten days thereafter in the case of Non-Payment of Premium, B) not less than ten days thereafter in case any bankruptcy or debtor relief proceeding is brought by or against you under Title 11 of the United States Code, and C) not less than the number of days thereafter stated in the Schedule, in all other cases, such cancellations shall be effective.

## SCHEDULE

**NUMBER OF DAYS**

90



DATE OF ISSUE: 03-19-14

**ST ASSIGN:**

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WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 10 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## AMENDED CANCELLATION CONDITION ENDORSEMENT

We agree that Part Six, D. Cancellation, item 2 of the policy, is amended as follows:

We may cancel this policy by mailing or delivering to you at the address shown on the Information Page written notice stating when A) not less than ten days thereafter in the case of Non-Payment of Premium, B) not less than ten days thereafter in case any bankruptcy or debtor relief proceeding is brought by or against you under Title 11 of the United States Code, and C) not less than the number of days thereafter stated in the Schedule, in all other cases, such cancellations shall be effective.

### SCHEDULE

NUMBER OF DAYS

90



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 11 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## NOTICE OF CANCELLATION

Except for non-payment of premium by you, we agree that no cancellation or limitation of this policy shall be effective until written notice in accordance with item 2 of the Schedule has been mailed to you. Mailing notice to you at the mailing address shown in item 1 of the Schedule shall be sufficient to prove notice.

### SCHEDULE

1. NAME



ADDRESS

2. NUMBER OF DAYS WRITTEN NOTICE: 90

DATE OF ISSUE: 03-19-14 ST ASSIGN:



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 36 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**CANCELLATION AMENDMENT—WASHINGTON**

This policy shall not be cancelled by the Company until at least forty-five days prior to the effective date of such cancellation a written notice is actually delivered or mailed to you or your representative. Cancellation of the policy for nonpayment of premium will however, only require a ten day written notice be sent prior to the effective date of cancellation.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 99 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**NORTH DAKOTA AMENDATORY ENDORSEMENT  
(EMPLOYERS LIABILITY COVERAGE)**

This endorsement applies only to work in North Dakota.

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

1. Except as provided in 2. below, we may examine and audit your books and records as they relate to this policy at any time during the policy period and up to three years afterward.
2. Any audit conducted to determine the premium due or to be refunded must be completed within 180 days after:
  - a. The expiration date of the policy; or
  - b. The anniversary date, if this is a continuous policy or a policy written for a term longer than one year; unless you agree in writing to extend the audit period.

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

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



DATE OF ISSUE: 03-19-14 ST ASSIGN:

002831

## FLORIDA NOTICE OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

This notice is being sent to you with respect to your workers compensation and employers liability insurance policy. This notice does not replace the separate Florida Terrorism Risk Insurance Program Reauthorization Act Endorsement (WC 09 04 03 A) that is attached to your current policy and which remains in effect as applicable.

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

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

Your policy provides coverage for workers compensation losses caused by acts of terrorism or war, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy.

The premium charge for the coverage your policy provides for terrorism or war losses is shown in Item 4 of the Information Page or the Schedule in the Florida Terrorism Risk Insurance Program Reauthorization Act Endorsement (WC 09 04 03 A) that is attached to your policy, and this amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2014 in the event of TRIPRA's expiration, subject to regulatory review in accordance with applicable state law.

You need not do anything further at this time.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 21 (C)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

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

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

For purposes of this endorsement, the following definitions apply:

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

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

**Schedule**

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

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14

ST ASSIGN:

Page 1 of 1



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 G2 ( B )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT

### A. General Conditions

1. This endorsement applies to the Workers Compensation Insurance, Employers Liability Insurance, and to the Other States insurance coverage provided in this policy. This endorsement also applies to the insurance provided by any endorsement to this policy.
2. This endorsement applies between you and us. It does not affect the rights of others under the policy. Nor does it change our obligations under the policy except as otherwise stated in this endorsement. We will remain responsible for the full payment of all claims under this policy without regard to your ability or intention to reimburse us for the deductible amount, provided that this does not release you from your obligation to reimburse us.
3. In consideration of a reduced premium, you have agreed to reimburse us up to the deductible amounts stated in the Schedule at the end of this endorsement for all payments legally required under the policy, including Allocated Loss Adjustment Expense(s), where you have elected to include such expense as stated in the Schedule. You will also reimburse us for Claim Handling Expenses as set forth in the Schedule.

### B. Deductible - Each Accident

1. The deductible amount - each accident stated in the Schedule is the most you must reimburse us for indemnity and medical benefits and damages combined for bodily injury to one or more employees as the result of any one accident or for any one employee due to bodily injury by disease. All or a portion of the Allocated Loss Adjustment Expense may be included in the deductible amount depending upon the option selected by you, as stated in the Schedule.

### C. Aggregate Deductible Limit

1. The amount stated in the Schedule as the aggregate deductible limit is the most you must reimburse us for the sum of all indemnity and medical benefits and damages within the Each Accident Deductible. All or a portion of the Allocated Loss Adjustment Expense may be included in the aggregate deductible limit depending upon the option selected by you, as stated in the Schedule.

We will not reduce the aggregate deductible limit if:

- (a) this endorsement is issued for a term of less than (1) year, or
- (b) the policy is canceled for any reason by you or by us before the end of the policy period.

### D. Effect of Deductible on Employers Liability Limits

1. The applicable limits of liability as respects the Employers Liability insurance coverage provided in this policy will be reduced by the deductible amount(s) applicable to the corresponding type of Employers Liability claim for accident or disease covered under this policy. In the event of a claim, our liability to pay is the amount available for damages that remains after the subtraction of the specific deductible amount from the applicable limits of liability. The payment of Allocated Loss Adjustment Expense(s), will not reduce, and is in addition to the limits of liability, but where elected by you, such expense will be reimbursed to us by you as stated in the Schedule.

### E. Allocated Loss Adjustment Expense

1. Allocated Loss Adjustment Expense (or "ALAE") encompasses the following costs of a carrier which can be directly allocated to a particular claim:



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 G2 (B)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

- a. Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representatives.
- b. Court, Alternate Dispute Resolution and other specific items of expense whether incurred by an outside vendor or by one of our employees, including but not limited to:
  - Medical examinations of a claimant to determine the extent of our liability, degree of permanency or length of disability;
  - Expert medical or other testimony;
  - Autopsy;
  - Witnesses and summonses;
  - Copies of documents such as birth and death certificates and medical treatment records;
  - Arbitration fees;
  - Fees or costs for surveillance or other professional investigations which are conducted as part of the handling of a Claim;
  - Fees or costs for loss prevention and engineering personnel and fees or costs for rehabilitation nurses or other nurses, if the cost of such nurses is not included in losses, for services which are conducted as part of the handling of a Claim;
  - Appeal bond costs and appeal filing fees.
- c. Medical cost containment expenses incurred with respect to a particular Claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include but are not limited to:
  - Bill auditing expenses for any medical or vocational services rendered, including hospital bills (in-patient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.
  - Hospital and other treatment utilization reviews, including pre-certification/pre-admission, concurrent or retrospective reviews.
  - Preferred provider Network/Organization expenses.
  - Medical fee review panel expenses.
- d. Expense(s) not defined as losses which are directly related to and directly allocated to the handling of a particular Claim and are required to be performed by statute or regulation.

The following shall not be included as "Allocated Loss Adjustment Expense":

- 1. Salaries, overhead and traveling expenses of carrier employees, except for employees while doing activities previously listed as allocated expenses.
- 2. Fees paid to independent Claims professionals or attorneys (hired to perform the function of Claim investigation normally performed by Claim adjusters) for developing and investigating a Claim so that a determination can be made of the cause, extent or responsibility for the injury, disease or damage, including evaluation and settlement of covered Claims.
- 3. Expenses which are defined as either an indemnity or medical loss.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 G2 (B)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

2. If the option indicated on the schedule is for you to reimburse us for the total Allocated Loss Adjustment Expense with ALAE above the deductible limits being shared pro rata between you and us, your pro rata share of ALAE will be determined as follows:
  - (1) When ALAE is excluded from the deductible amount each accident and excluded from the aggregate deductible amount, we will calculate the ratio of the deductible amount each accident to the total loss. We will then multiply ALAE by that ratio to determine your pro rata share.
  - (2) When ALAE is excluded from the deductible amount each accident and included in the aggregate deductible amount, we will calculate the ratio of medical and indemnity loss within the aggregate deductible limit to the total medical and indemnity losses. We will then multiply ALAE by that ratio to determine your pro rata share.

**F. Recovery From Others**

1. If we recover any payments under this policy from anyone liable for the injury, the amount we recover will be applied as follows:
  - (a) First, to any payments made by us in excess of the deductible amount; and
  - (b) The remainder, if any, will be applied to reduce the deductible amount reimbursed by you.

**G. Cancellation**

1. If you fail to reimburse us for any amounts as required by this endorsement, or, if you fail to provide security in a form and amount acceptable to us, we may cancel this policy in accordance with the cancellation conditions. We will remain fully responsible for the full payment of all claims for bodily injury by accident or bodily injury by disease that occurred prior to the effective date of cancellation.

**H. Sole Representation**

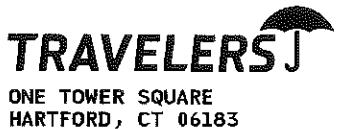
1. The insured first named in Item 1. of the Information Page will act on behalf of all the named insureds with respect to:
  - (a) Changes to this endorsement;
  - (b) Obligations to receive premiums; or
  - (c) Giving or receiving notice of cancellation.

**I. Your Duties and Understanding**

1. All bodily injury by accident or bodily injury by disease for which you are responsible shall be promptly reported to us. You further understand that all such bodily injuries and their cost shall be included in experience data used to determine the experience rating for your policy, regardless of the eligibility of such claims for full or partial reimbursement under the deductible provisions of this policy.

**J. Other Rights and Duties**

1. All other terms of the policy, including those which govern the following items, apply irrespective of this deductible endorsement:
  - (a) Our right and duty to defend any claim, proceeding or suit against you, and
  - (b) Your duties if injury occurs.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 G2 (B)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SCHEDULE**

1. Deductible Amount \$ 250,000 Each Accident (including disease as defined in Deductible – Each Accident).  
 Amount \$ \_\_\_\_\_  
 No Aggregate Deductible Limit applies.
2. Aggregate Deductible Limit Option (option that applies is indicated by "X")  
 Amount \$ \_\_\_\_\_  
 No Aggregate Deductible Limit applies.
3. Allocated Loss Adjustment Expenses (ALAE) (option that applies is indicated by "X")  
 Included in the deductible each accident limit and included in the aggregate amount; or  
 Excluded from the deductible each accident limit and \_\_\_\_\_ aggregate deductible amount, and (option that applies is indicated by "X")  
("included in" or  
"excluded from")
  - reimbursed by you for total amount of expense regardless of deductible limit(s); or
  - reimbursed by you for total amount of expense; ALAE above the deductible limits will be shared pro rata between you and us; or
  - reimbursed by you as a flat charge against the policy, flat charge: \_\_\_\_\_;  
(enter dollar amount)
4. Claims Handling Expenses other than ALAE are (option that applies indicated by "X"):  
 reimbursed by you as a percentage charge for each loss;  
percentage charge: \_\_\_\_\_; or  
 reimbursed by you as a charge for each claim;  
charge per claim \$ 175.00CM, 1375.00CB, 75.00 PER INCIDENT; or  
 reimbursed by you as a flat charge against the policy;  
flat charge \$ \_\_\_\_\_;

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





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 G7 ( E )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FEDERAL TERRORISM RISK INSURANCE ACT DISCLOSURE

This endorsement applies only to your Workers Compensation Benefit obligations.

On December 26, 2007, the President of the United States signed into law amendments to the Terrorism Risk Insurance Act of 2002 (the "Act"), which, among other things, extend the Act and expand its scope. The Act establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in the Act) caused by "acts of terrorism". An "act of terrorism" is defined in Section 102(l) of the Act to mean 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 – to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have 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 to have 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.

The federal government's share of compensation for Insured Losses is 85% of the amount of Insured Losses in excess of each Insurer's statutorily established deductible, subject to the "Program Trigger", (as defined in the Act). In no event, however, will the federal government or any Insurer be required to pay any portion of the amount of aggregate Insured Losses occurring in any one year that exceeds \$100,000,000,000, provided that such Insurer has met its deductible. If aggregate Insured Losses exceed \$100,000,000,000 in any one year, your coverage may therefore be reduced. The charge for this exposure is included in the premium indicated in your policy, and does not include any charge for the portion of losses covered by the federal government under the Act. The charge that has been included for this coverage is:

Except as disclosed in state specific changes endorsements:

4% of your total Workers Compensation premium. Deductible and guaranteed cost policies (if any) will be subject to any applicable adjustments or audits. For retrospective policies (if any), the charge will be a flat charge which is charged at policy inception, not subject to any retrospective premium adjustments or audits.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 01 19 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## TERRORISM RISK INSURANCE PROGRAM ENDORSEMENT

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

### Definitions

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

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments resulting thereto:

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

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

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

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

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

### Limitation of Liability

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



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**Policyholder Disclosure Notice**

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

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

Section D. of Part Five of the policy is replaced by this provision.

**PART FIVE**

**PREMIUM**

**D. Premium** is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The due date for audit and retrospective premiums is the date of the billing.**





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 01 01 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**LONGSHORE AND HARBOR WORKERS' COMPENSATION  
ACT COVERAGE ENDORSEMENT - CALIFORNIA**

This endorsement applies only to work subject to the Longshore and Harbor Workers' Compensation Act in California. The policy applies to that work as though California were listed in item 3.A of the Information Page.

General Section C. Workers' Compensation Law is replaced by the following:

**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 and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers' or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Longshore and Harbor Workers' Compensation Act.

This endorsement does not apply to work subject to the Defense Base Act, the Outer Continental Shelf Lands Act, or the Nonappropriated Fund Instrumentalities Act.

The estimated premium for the Longshore and Harbor Workers' Compensation Act coverage provided by this endorsement is as shown in the Schedule below or item 4 of the Information Page.

**SCHEDULE**

CODE NO.	CLASSIFICATION	ESTIMATED ANNUAL REMUNERATION	RATE PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
-------------	----------------	-------------------------------------	--------------------------------------	--------------------------------

**SEE INFORMATION PAGE SCHEDULE(S)**

Total Estimated Annual Premium \$



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 04 03 01 (B)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## POLICY AMENDATORY ENDORSEMENT – CALIFORNIA

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

- 1. Minors Illegally Employed – Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.
- 2. Punitive or Exemplary Damages – Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.
- 3. Increase in Indemnity Payment – Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars (\$100).

If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.

- 4. Application of Policy.** Part One, "Workers Compensation Insurance", A, "How This Insurance Applies", is amended to read as follows:

This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.

- 5. Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.
- 6. Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.
- 7. Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.
- 8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:**

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

DATE OF ISSUE: 03-19-14 ST ASSIGN:

Page 1 of 2

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WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 04 03 01 (B)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

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

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

It is further agreed that this policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in this policy or such endorsements shall affect such contract or any rights, duties, or privileges arising therefrom.

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

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

Endorsement Effective  
Insured

Policy No.  
Insurance Company

Endorsement No.

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 05 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE  
ENDORSEMENT - CALIFORNIA**

If the employer named in Item 1 of the Information Page has in his employment persons not entitled to compensation under Division 4 of the Labor Code of the State of California, this policy shall operate as an election on the part of the employer to come under the compensation provisions of Division 4 with respect to those persons described in the Schedule below.

This policy applies to those persons described in the Schedule below as employees.

**SCHEDULE**

ALL EMPLOYEES NOT SUBJECT TO THE WORKERS' COMPENSATION LAW



DATE OF ISSUE: 03-19-14

ST ASSIGN:

002838



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 04 03 60 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT – CALIFORNIA

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

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

A. How This Insurance Applies

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

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in California.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

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

1. Exclusion 1 is amended to read as follows:

1. liability assumed under a contract.

2. Exclusion 2 is deleted.

3. Exclusion 7 is amended to read as follows:

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

4. The following exclusions are added:

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



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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancelation table below:

Short Rate Cancelation Table

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708



ONE TOWER SQUARE  
HARTFORD, CT 06183

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815



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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

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DATE OF ISSUE: 03-19-14

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 01 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## CALIFORNIA CANCELLATION ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because California is shown in Item 3.A. of the information page.

The 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 Information Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Items (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of 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.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 09 03 03 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

- C. Exclusion 5, Section C. of Part Two of the policy, is replaced by the following:

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.



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WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 04 02 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

- A. 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.
- B. If the factor is an increase over that shown on the Information Page, it will apply as of the policy effective date; or if the anniversary rating date is different from the policy effective date it will apply as of the anniversary rating date. Your premium will be calculated:
  - 1. Retroactively to the effective date of the policy or to the anniversary rating date if the adjustment is within the first 90 days of the policy period or the anniversary rating date;
  - 2. On a pro rata basis from the date we endorsed the policy if the adjustment is more than 90 days after the effective date of the policy or the anniversary rating date.The adjustment will be retroactive to the effective date of the policy period or to the anniversary rating date when:
  - a. The change in experience modification is the result of a revision in your classifications;
  - b. The delay in the calculation of the experience modification is due to your failure to make available all your records for examination and audit as provided in Part Five-G (Audit) of the policy.
- C. If the factor is a decrease from that shown on the Information Page, it will apply retroactively to the policy effective date or the anniversary rating date if different from the policy effective date.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 09 04 07 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

This endorsement adds the following provisions to Part Five – Premium, G. Audit, of the policy:

We are required to complete the premium audit process no later than 90 days after policy termination. If you fail to return voluntary audit requests or refuse to cooperate in completing a final physical audit, you must pay a premium to us not to exceed three times the most recent estimated annual premium on this policy subject to the following conditions:

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.
2. We document the audit file regarding the above attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

If you do not provide all of the specific records required and if we satisfy the conditions above on or before 90 days from the date of policy termination, we may continue to try and conduct the audit and/or re-open the audit for up to three years from the date of policy termination. Alternatively, we may immediately bill you for your final premium. If you provide all of the specific records required to complete the premium audit process within the three year period, we will determine your final premium in accordance with Part Five – Premium, E. Final Premium of the policy.



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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14 ST ASSIGN:

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 09 06 06 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.



ONE TOWER SQUARE  
HARTFORD, CT 06183

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 10 04 02 (00)**

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## GEORGIA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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



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

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

**Endorsement Effective  
Insured**

Policy No.

Endorsement No.     
Premium \$

### Insurance Company

Countersigned by

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ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 10 06 01 ( A )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## GEORGIA CANCELATION, NONRENEWAL AND CHANGE ENDORSEMENT

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

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

### D. Cancelation, Nonrenewal and Change

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

- a. If only your interest is affected, the effective date of cancelation 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 canceled 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 cancelation.

Our notice will state the effective date of cancelation, 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 cancelation 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 cancelation 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 cancelation or nonrenewal by certified mail, return receipt requested, to your last address of record at least 75 days prior to the effective date of cancelation 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 or 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 cancelation notice except as provided for above.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 12 06 01 ( D )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## ILLINOIS AMENDATORY ENDORSEMENT

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

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

### **Inspection**

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

### **Cancellation**

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail to each named insured and to the broker or the agent of record advance written notice stating when the cancellation is to take effect.
3. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least ten days before the cancellation is to take effect. If we cancel for any other reason, we will mail the notice:
  - a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;
  - b. At least 60 days before the cancellation is to take effect if the policy has been in force for more than 60 days.
4. If this policy has been in effect for 60 days or more, we may cancel only for one of the following reasons:
  - a. Nonpayment of premium.
  - b. The policy was issued because of a material misrepresentation.
  - c. You violated any of the material terms and conditions of the policy.
  - d. There are unfavorable underwriting factors, specific to you, that were not present when the policy took effect.
  - e. The Director has determined that we no longer have adequate reinsurance to meet our needs.
  - f. The Director has determined that continuation of coverage could place us in violation of the laws of Illinois.
5. Our notice of cancellation will state our reasons for canceling.
6. The policy period will end on the day and hour stated in the cancellation notice.





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 12 06 01 ( D )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**Nonrenewal**

1. We may elect not to renew the policy. If we fail to give 60 days notice, the policy will automatically be extended for one year. The nonrenewal notice will be sent to your last known mailing address. We will maintain proof of mailing of the notice to not renew the policy. An exact and unaltered copy of such notice will also be sent to the insured's broker, if known, or the agent of record at the last mailing address known by the company.
2. Our notice of nonrenewal will state our reasons for not renewing.
3. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
  - a. You notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
  - b. You fail to pay all premiums when due; or
  - c. You obtain other insurance as a replacement of the policy.

**Sole Representative**

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

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

**Audit**

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

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned By \_\_\_\_\_

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DATE OF ISSUE: 03-19-14

ST ASSIGN:



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 29 03 06 ( B )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

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

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

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

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

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

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

### F. Other Insurance

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

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

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 03-19-14

ST ASSIGN:



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 01 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**SPECIAL PENNSYLVANIA ENDORSEMENT – INSPECTION OF MANUALS**

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



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 02 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**NOTICE  
INSURANCE CONSULTATION SERVICES EXEMPTION ACT**

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

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

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

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



DATE OF ISSUE: 03-19-14 ST ASSIGN:

002846



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 37 06 03 (A)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

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

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

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

**Nonrenewal**

1. We may elect not to renew the policy. We will mail to each named insured, by first class mail, not less than 60 days advance notice stating when the nonrenewal will take effect. Mailing that notice to you at your mailing address last known to us will be sufficient to prove notice.
2. Our notice of nonrenewal will state our specific reasons for not renewing.
3. If we have indicated our willingness to renew, we will not send you a notice of nonrenewal. However, the policy will still terminate on its expiration date if:
  - a. you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
  - b. you fail to pay all premiums when due; or
  - c. you obtain other insurance as a replacement of the policy.

**Notice of Increase in Premium**

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

**Return of Unearned Premium**

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



ONE TOWER SQUARE  
HARTFORD, CT 06183

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

POLICY NUMBER: (TC2JUB-1112L07-9-14)

PENNSYLVANIA

**EMPLOYER ASSESSMENT ENDORSEMENT**

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

**EMPLOYER ASSESSMENT FORMULA:**

<b>Employer</b>	= Act 57 of 1997 Employer	<b>X</b>	Employer Assessment
<b>Assessment</b>	Assessment Factor		Premium Base

***Act 57 of 1997 Employer Assessment Factor***

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

***Employer Assessment Premium Base***

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

Code 0938

**EMPLOYER ASSESSMENT  
FACTOR**

See info page

**EMPLOYER ASSESSMENT**

\$ See info page





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 42 03 01 (F)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## TEXAS AMENDATORY ENDORSEMENT

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

### GENERAL SECTION

**B. Who Is Insured** is amended to read:

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

**D. State** is amended to read:

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

### PART ONE-WORKERS COMPENSATION INSURANCE

**E. Other Insurance** is amended by adding this sentence:

This Section only applies if you have other insurance or are self-insured for the same loss.

**F. Payments You Must Make**

This Section is amended by deleting the words "workers compensation" from number 4.

**H. Statutory Provisions**

This Section is amended by deleting the words "after an injury occurs" from number 2.

### PART TWO-EMPLOYERS LIABILITY INSURANCE

**C. Exclusions**

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

**6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada.**

This exclusion does not apply to bodily injury to a citizen or resident of the United States of America, Mexico or Canada who is temporarily outside these countries.

**D. We Will Defend**

This Section is amended by deleting the last sentence.

### PART FOUR-YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

**6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.**

### PART FIVE-PREMIUM

**A. Our Manuals** is amended by adding this sentence:

In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 42 03 01 ( F )

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**C. Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers compensation insurance.

**E. Final Premium**

Number 2 is amended to read:

2. If you cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

**PART SIX-CONDITIONS**

**A. Inspection** is amended by adding this sentence:

Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be canceled by us.

**C. Transfer of Your Rights and Duties** is amended to read:

Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

**D. Cancelation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancelation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Workers' Compensation Commission.
3. Notice of cancelation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancelation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancelation or nonrenewal becomes effective if we cancel or do not renew because of:
  - a. Fraud in obtaining coverage;
  - b. Misrepresentation of the amount of payroll for purposes of premium calculation;
  - c. Failure to pay a premium when payment was due;
  - d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;
  - e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.
4. If another insurance company notifies the Texas Workers' Compensation Commission that it is insuring you as an employer, such notice shall be a cancelation of this policy effective when the other policy starts.





ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 42 03 01 (F)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**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.



WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 42 03 04 (A) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule, but this waiver applies only with respect to bodily injury arising out of the operations described in the Schedule where you are required by a written contract to obtain this waiver from us.

This endorsement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

The premium for this endorsement is shown in the Schedule.

### Schedule

1.  Specific Waiver

Name of person or organization

Blanket Waiver

Any person or organization for whom the Named Insured has agreed by written contract to furnish this waiver.

2. Operations:

ALL TX OPERATIONS

3. Premium:

The premium charge for this endorsement shall be 2 percent of the premium developed on payroll in connection with work performed for the above person(s) or organization(s) arising out of the operations described.

4. Advance Premium: \$ SEE SCHEDULE





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 42 04 07 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**TEXAS—AUDIT PREMIUM AND  
RETROSPECTIVE PREMIUM ENDORSEMENT**

Section D of Part Five of the policy is replaced by the following provision:

**PART FIVE—PREMIUM**

**D. Premium Payments**

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 45 06 02 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**VIRGINIA AMENDATORY ENDORSEMENT**

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

For Virginia insurance Part Six.D. (Conditions-Cancelation) is replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us. You must provide written notice of your cancelation, including the date of and reasons for the cancelation, to the Workers Compensation Commission.
2. We may cancel this policy. We will provide you with 30 days notice of cancelation. We will provide the Workers Compensation Commission with immediate notice of such cancelation. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.
3. In the event of cancelation by you or us, you must provide 30 days written notice of the cancelation to your covered employees.
4. We may nonrenew your policy. We will provide 30 days notice to you and to the Workers Compensation Commission of our decision to nonrenew. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.
5. If you fail to pay the premium due on this policy we may cancel the policy by providing 10 days notice to you and to the Workers Compensation Commission.





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 J1 (00)

POLICY NUMBER: UB (TC2JUB-1112L07-9-14)

## TEXAS AMENDATORY ENDORSEMENT

As respects Texas exposures, the WORKERS COMPENSATION DEDUCTIBLE ENDORSEMENT is amended as follows:

Section 6 (b) is replaced by the following:

The aggregate will not be reduced if:

(b) the policy or this endorsement is canceled by you before the end of the policy period.



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 M2 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT – Large Deductible

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

### Definitions

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

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States as meeting all of the following requirements:
  - a. The act is an act of terrorism.
  - b. The act is violent or dangerous to human life, property or infrastructure.
  - c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
  - d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.
5. "Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

### Limitation of Liability

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



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 M2 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**Policyholder Disclosure Notice**

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

**Schedule**

\$0.01 per \$100 of Remuneration

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



ONE TOWER SQUARE  
HARTFORD, CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 46 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## ILLINOIS AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Illinois is shown in Item 3.A. of the Information Page. Exclusion C., 1., of Part Two (Employers Liability) of the policy is replaced by the following:

**C. Exclusions**

**1. is replaced by:**

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner.

This exclusion also does not apply to your liability to a third party by reason of a claim or suit against you by that third party for contribution under the Illinois Joint Tortfeasor Contribution Act for damages claimed against such third party as a result of injury to your employee if such liability is otherwise covered under this Part Two of the policy, and you have that liability because you have waived, in a written contract, your right to limit such liability to the amount of the workers compensation benefits paid for that injured employee under the Illinois Workers Compensation Act. This exception only applies to bodily injury by accident that occurs after that contract was made and to bodily injury by disease caused or aggravated by conditions to which the injured employee's last day of exposure occurs after that contract was made.





WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 99 06 47 (00) - 001

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## AMENDED CANCELLATION CONDITION ENDORSEMENT

We agree that Part Six, D. Cancellation, item 2 of the policy, is amended as follows:

We may cancel this policy by mailing or delivering to you at the address shown on the Information Page written notice stating when A) not less than ten days thereafter in the case of Non-Payment of Premium, B) not less than ten days thereafter in case any bankruptcy or debtor relief proceeding is brought by or against you under Title 11 of the United States Code, and C) not less than the number of days thereafter stated in the Schedule, in all other cases, such cancellations shall be effective.

### SCHEDULE

#### NUMBER OF DAYS

90

## NEW JERSEY

### NOTICE OF ELECTION – PROPRIETORS AND PARTNERS WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

The New Jersey Workers' Compensation Law was amended effective April 13, 2000. The amendment permits **election** by a self-employed person or partners of any partnership including partners of a limited liability partnership and members of a limited liability company actively performing services on behalf of the business to be deemed employees for the purpose of receipt of benefits and the payment of premiums. This election does not affect the insurance obligations for employees other than the self-employed person, partners or members.

The election must be made at the time the policy is purchased or renewed and must be effective at the inception date of the policy. It is important to note that the election cannot be rescinded during the policy period and that in the case of any partnership including a limited liability partnership or limited liability company, **ALL** of the partners or **ALL** of the members must elect the coverage. You will be required to pay a premium based on the remuneration and duties of the self-employed person or each partner or each member.

The insurer or insurance producer shall not be liable in an action for damages on account of the failure of a business, limited liability partnership, limited liability company or partnership to elect to obtain workers' compensation coverage for a self-employed person, limited liability partner, limited liability company member or partner, unless the insurer or insurance producer causes damage by a willful, wanton or grossly negligent act of commission or omission.

Whether electing or rejecting coverage, it will be necessary to complete all of the information requested below. This completed form must then be returned to the insurer/producer. A copy of this Notice and proof of mailing should be retained for your records. If you received this form in relation to a renewal of insurance, and fail to execute and return it to the insurer/producer, coverage will continue as per the expiring policy.

NAME OF BUSINESS			
COVERAGE IS ELECTED <input type="checkbox"/>	COVERAGE IS REJECTED <input type="checkbox"/>	BUSINESS IS A CORPORATION or OTHER FORM OF ORGANIZATION <input type="checkbox"/>	Always complete this section

Name(s) of Proprietor or ALL Partners (Please Print)	Estimated Annual Wage	Duties
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Signature: _____	Date: _____
Proprietor or a Partner	

Always  
complete  
this section

Complete  
this section  
only when  
coverage  
is elected

Always  
complete  
this section





## Travelers Medical Provider Network (MPN) Plan – CALIFORNIA Necessary Action for MPN Implementation

Dear Policyholder:

As your workers compensation insurer, Travelers is pleased to include your Company in our California Medical Provider Network (MPN) plan. Travelers has an extensive MPN with physicians who understand workers compensation and are experienced in providing expert care for injured workers. Our program ensures that every covered employee that suffers a work-related injury or illness has access to prompt medical care and an improved likelihood of a safe return to work as soon as medically appropriate. MPN utilization can reduce overall workers compensation claim payouts by providing greater control over medical fees and obtaining more favorable medical treatment outcomes. Your role is crucial to the success of the MPN program. Together, we can better manage your Workers Compensation claims within the MPN.

**The MPN is a standard product in all Travelers workers compensation policies, and all policyholders are expected to enroll. This information is being provided to you to help you understand the requirements for proper MPN implementation.**

The State Division of Workers' Compensation (DWC) regulates how an MPN is implemented. Sections § 9767.12 and § 9767.16 of Title 8, California Code of Regulations specify what notices are to be provided to employees, as well as when and how they are to be provided. Travelers has an **Employer MPN Implementation Checklist** (included in the **MPN Enrollment Kit**) that walks policyholders through the requirements of the enrollment and implementation process. The Employer Checklist, MPN Enrollment Kit, and all other Travelers MPN documents are located on [www.travelers.com](http://www.travelers.com). Please type this web address into your browser to download the necessary forms:

[www.travelers.com/CAMPN](http://www.travelers.com/CAMPN)

If you have any questions regarding the MPN implementation process, or any of the MPN documents, you can speak with a **Travelers MPN Enrollment Representative** by calling **(800) 287-9682**. Please listen for the prompts for *Employers* or *Employer Representatives*. A "Frequently Asked Questions" page is also available through the above web address. Look for the link called **FAQ – MPN**.

In addition to following the notification requirements listed on the **Employer MPN Implementation Checklist**, we also recommend that you:

- Make sure your management staff has instructions on how to access the MPN Medical Provider directory via <http://www.mywcinfo.com>.
- Select an occupational medicine clinic, urgent care clinic, or, an acute care hospital from the MPN to serve as your designated initial injury treatment facility for each plant/location. Contact this facility and inform them that you are participating in the Travelers Medical Provider Network Plan. Update the State Posting Notices to include the name, address, and phone number of the facility.
- Review your procedures for handling work-related injuries, your modified duty policy, and your safety committee operation with your management staff.

We believe the MPN program will provide better overall workers compensation outcomes for you as an employer. If you should have any questions regarding the Travelers MPN, please contact the Travelers MPN Team at **(800) 287-9682** or **CAMPN@travelers.com**.

Sincerely,

Travelers

W04NIB09

Page 1 of 1



## MEDICAL AUTHORIZATION

RE: Name:

Date:

SS#:

Claim Number:

DOB:

### YOU ARE HEREBY AUTHORIZED TO RELEASE TO

NIPPONKOA Insurance Company, Limited (U.S. Branch)  
Travelers Indemnity Company and its Property/Casualty affiliates  
or Constitution State Services, LLC  
215 Shuman Boulevard  
Naperville, IL 60567  
Fax: 877/786-5567

or any representative acting on its behalf, including my employer, and to permit them to examine and/or copy:

Any and all hospital records, medical records, psychological records, x-ray films and their reports, all tests of any type and character and their reports, statements of charges and any and all records of medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense in your possession or control pertaining to the undersigned. (Illinois Mental Health and Developmental Disabilities Confidentiality Act—REF. 740 ILCS 110/1 et seq; and, Illinois Workers Compensation Act 820 ILCS 305/8(a))

You are also authorized to discuss with them my injuries, physical condition, treatment and care and to furnish them with a written report regarding same.

The purpose for releasing this information is:

- (A) To facilitate the evaluation of my claim for Workers' Compensation benefits. (REF: 50 IL Admin Code, Ch II § 7110.70).
- (B) To permit said disclosed information to be admitted into evidence at a hearing on my claim for said benefits pursuant to the appropriate rules of practice before the Illinois Industrial Commission.

A photostatic copy of this authorization shall be as valid as the original. This authorization is valid for the duration of the claim.

You are hereby released from any and all liability or responsibility, which could or might result because of the disclosure of any information pursuant to this authorization.

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DATE

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SIGNATURE

---

PRINT NAME

W12C1G07



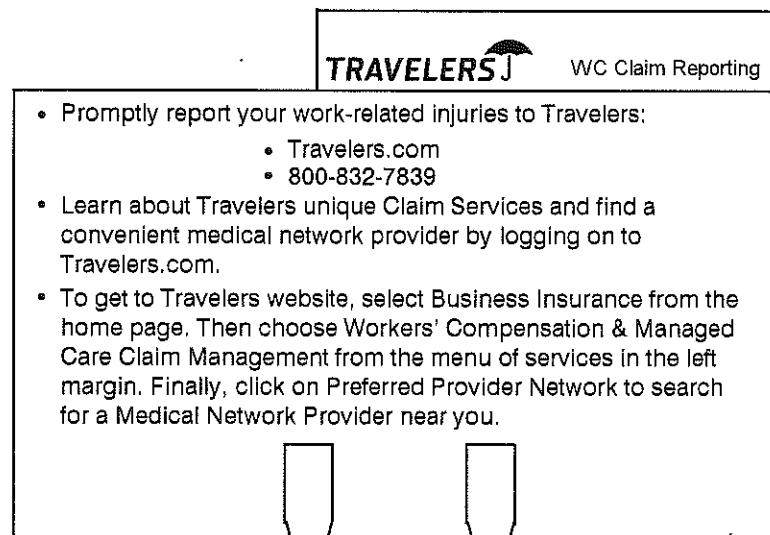
## If Your Employee Is Injured At Work

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

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

1. Seek appropriate medical care for the Employee.
2. If the injury or illness is acute, the Employer should always send the Employee to the nearest medical emergency department.
3. If the injury or illness is not acute, the Employer may suggest that the Employee seek treatment from the nearest Medical Network Provider. Medical Network Providers understand work-related illnesses and injuries, are credentialed to help assure quality care, and cooperate to achieve a medically appropriate return to work for the Employee. Medical Network Providers (hospitals, initial care clinics, specialists, testing, therapy, etc.) are available in all 50 States and the District of Columbia. Even before an illness or injury occurs, it may be helpful for the Employer to build a relationship with a convenient Medical Network Clinic or Hospital that will provide initial treatment for ill or injured Employees.
4. The Employee's Supervisor should gather pertinent facts about the work-related illness or injury and may use the Worksheet For Workers' Compensation Telephone Reporting provided by Travelers as a guide.
5. As soon as possible, the Employer should report all work-related illnesses or injuries to Travelers by,
  - using Travelers business insurance online reporting web site at [travelers.com](http://travelers.com)
  - dialing our toll free number, **1-800-832-7839**. If needed at that time, Travelers Customer Service Representative can provide the name of a convenient Medical Network Provider. Prompt reporting of work-related illnesses and injuries is key in helping to reduce total claim costs. At the conclusion of the phone call, the Travelers Customer Service Representative will provide a claim number that should be retained for the Employer's reference and also provided to the ill or injured Employee.

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





**NOTICE TO EMPLOYEES**

Longshore and Harbor Workers' Compensation Act

U.S. Department of Labor

Employment Standards Administration

Office of Workers' Compensation Programs

(Employer) **PREFERRED FREEZER SERVICES LLC**

This employer is insured to provide compensation benefits (including medical and hospital care) to its employees, or monetary benefits to eligible survivors, in case of work-connected injury, occupational illness or death, in accordance with the provisions of the above law and rules of the Office of Workers' Compensation Programs.

- **NOTIFY YOUR EMPLOYER IMMEDIATELY.** If possible, complete Form LS-201, Notice of Injury, available from your employer. You should give notice of injury to the following person(s):  
\_\_\_\_\_  
\_\_\_\_\_

## **WHAT TO DO WHEN INJURED AT WORK**

- **MEDICAL TREATMENT.** Request authority (Form LS-1) from your employer for treatment by the physician you choose. You may not select a physician that is not authorized by the Office of Workers' Compensation Programs to provide medical care under the Act. Your employer has a list of physicians who are not authorized. In an emergency or if unable to contact your employer, go to the nearest hospital or physician, but be sure to let your employer know as soon as possible.
- **DISABILITY.** If you are disabled more than 3 days, contact your employer or the insurance company indicated below for payment of compensation, payable 14 days after your employer has knowledge of injury.
- **IMPORTANT!** The law requires you to give written notice of injury (Form LS-201) to your employer and to the Office of Workers' Compensation Programs within 30 days. Additional time may be allowed for certain hearing loss and occupational disease claims. The address of the Office of Workers' Compensation Programs District Office for this area is:  
\_\_\_\_\_  
\_\_\_\_\_

Insurance Carrier for This Employer	For Further Assistance and Information
Name THE TRAVELERS INSURANCE COMPANIES	On request, the Office of Workers' Compensation Programs will explain benefits and proceedings under the above Act. In addition, the Office of Workers' Compensation Programs will inform employees receiving compensation about medical and vocational rehabilitation services, and will assist in obtaining such services.
Address ONE TOWER SQUARE HARTFORD, CT 06183	
Telephone 800 832-7839	
Policy Number (TC2JUB-1112L07-9-14)	Expiration Date of Policy 03-01-15

Authorized Signature for the Employer

Date Signed

**This Notice must be posted and maintained in a conspicuous place in and about the place of business.  
(33 U.S.C. 934)**

### **Important Notice**

Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed \$10,000, by imprisonment not to exceed five years, or by both.



## WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

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

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

### ACCOUNT/ACCIDENT INFORMATION

CALLER'S PHONE NUMBER/EXTENSION (      )	CALLER'S TITLE	CALLER'S NAME	
SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)		REPORTING STATE <input type="checkbox"/> SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?

YES  NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY/INSURED'S NAME

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS
DATE OF INJURY	TIME OF INJURY	

ACCIDENT DESCRIPTION

### EMPLOYEE INFORMATION

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

### EMPLOYEE JOB INFORMATION

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

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION

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

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME	SUPERVISOR'S PHONE NUMBER: (      )	BEST HOURS TO CONTACT
-------------------	--	-----------------------

### ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

DO YOU QUESTION THE VALIDITY OF THE CLAIM?

YES  NO

WITNESS INFORMATION/OTHERS INVOLVED

NAME (FIRST, MI, LAST)

ADDRESS

PHONE NUMBER

**CONTINUED ON REVERSE SIDE**

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**INJURY INFORMATION**

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

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

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

 YES     NO

TREATMENT ("X" ALL THAT APPLY)

<input type="checkbox"/> FIRST AID --	TREATMENT AND DATE OF 1 <sup>st</sup> TREATMENT	
<input type="checkbox"/> HOSPITAL/CLINIC --	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 <sup>st</sup> TREATMENT, LENGTH OF STAY AMBULANCE USED?	
	WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PHYSICIAN --		

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

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**CUSTOMER SPECIFIC INFORMATION**

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**ADDITIONAL COMMENTS & INFORMATION**

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

### Alabama

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

### Alaska - No Additional State Questions

### Arizona

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

### Arkansas - No Additional State Questions

### California

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

### Colorado

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

### Connecticut - No Additional State Questions

### Delaware

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

### District of Columbia

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

### Florida - No Additional State Questions

### Georgia

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

### Hawaii

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

### Idaho - No Additional State Questions

### Illinois

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

### Indiana - No Additional State Questions

### Iowa - No Additional State Questions

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

### Kentucky - No Additional State Questions

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

### Maine

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

### Maryland - No Additional State Questions

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

### Michigan

Federal ID Number:

### Minnesota

Date employer notified of lost time:  
NAICS Code Number:

### Mississippi - No Additional State Questions

### Missouri - No Additional State Questions

### Montana - No Additional State Questions

### Nebraska - No Additional State Questions

### Nevada

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

### New Hampshire

Federal I.D. Number:  
Was the employee injured in his/her regular occupation (Y/N):  
Was injured hired in New Hampshire (Y/N):

Number of Full-Time Employees:  
Number of Part-Time Employees:  
If leased or temporary worker, provide the Client's Business Name:  
Was accident caused by injured's failure to use safeguards or follow regulations (Y/N):  
Probable Length of Disability:  
Returned to work (Y/N):

At what Occupation:  
Returned at Full Duty:  
Returned at Alternative/Light Duty:  
Initial treatment ("X" all that apply)  
No medical treatment: Care provided by employer only (on-site): Emergency Care: Hospitalized: Outpatient:  
Clinic:  
Office Visit: Other-explain:  
Is there a managed care program (Y/N):

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

<p>If Yes, Name of Provider:</p> <p>Is there a written safety program in force (Y/N):</p> <p>Is there an active safety committee (Y/N):</p> <p>Employee's Legal First Name (please validate):</p> <p><b>New Jersey</b> - No Additional State Questions</p> <p><b>New Mexico</b> - No Additional State Questions</p> <p><b>New York</b></p> <p>Did you provide medical care (Y/N):</p> <p>If Yes, When:</p> <p>Returned to work (Y/N):</p> <p>If Yes, at what Weekly Wage \$:</p> <p>Injured workers Work Week (indicate days regularly worked):</p> <p>Fatal (Y/N):</p> <p>If Yes, Name and Address of nearest relative:</p> <p>Relationship:</p> <p><b>North Carolina</b></p> <p>Regular Wages per Day \$:</p> <p>Average Weekly Wages with Overtime \$:</p> <p>Returned to work (Y/N):</p> <p>If Yes, at what Time: AM/PM</p> <p>If Yes, what Date:</p> <p>Return to work at what Wage \$: Per (Day, Week or Month):</p> <p>Return to work at what Occupation:</p> <p><b>North Dakota</b> - No Additional State Questions</p> <p><b>Ohio</b></p> <p>Time Accident Reported to employer: AM/PM:</p> <p>Has employee ever filed a previous application for this injury (Y/N):</p> <p>Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):</p> <p>If Yes, specify Claim Number and Body Parts:</p> <p>Employee's County:</p> <p>Current Employer's Risk Number:</p> <p><b>Oklahoma</b></p> <p>Was employment agreement made in Oklahoma (Y/N):</p> <p>SIC Number:</p> <p>Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):</p> <p><b>Oregon</b></p> <p>Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):</p> <p>Was accident caused by failure of machinery or product (Y/N):</p> <p>Did someone (not worker) cause accident (Y/N):</p> <p>Time worker left work: AM/PM:</p> <p><b>Pennsylvania</b></p> <p>Employee's County:</p> <p>Bureau Code:</p> <p>NAICS Code:</p> <p>Employer's County:</p> <p>Are you aware of a 'Panel of Physicians' for your Employer? (Y/N)</p> <tr><td><p><b>Rhode Island</b></p><p>Federal ID Number:</p><p>First Full Day Lost from work:</p><p>Unemployment Insurance Number:</p><p>State of Hire:</p><p>Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):</p><p>If Yes, Date Employer first Notified of medical treatment or lost time:</p><p>Category of Injury or Illness ("X" all that apply):</p><p>Injury: Illness: Occupational Disease: Repetitive Trauma: Occupational Hearing Loss: Unknown:</p><p><b>South Carolina</b> - No Additional State Questions</p><p><b>South Dakota</b></p><p>Federal ID Number:</p><p>Number of employees:</p><p>Body Part Injured Code (2 digits):</p><p>Cause of Injury Code (2 digits):</p><p>Nature of Injury Code (2 digits):</p><p>Was employee hired for temporary employment (Y/N):</p><p>Carrier Code:</p><p><b>Tennessee</b> - No Additional State Questions</p><p><b>Texas</b> - No Additional State Questions</p><p><b>Utah</b> - No Additional State Questions</p><p><b>Vermont</b></p><p>Federal ID Number:</p><p>Was employee hired in Vermont (Y/N):</p><p>Does the employer regularly employ 10 or more employees (Y/N):</p><p>Returned to work (Y/N): If Yes, at what Weekly Wage \$:</p><p>Was injured paid in full for the date disability began (Y/N):</p><p>Was employee injured at his/her regular occupation (Y/N):</p><p>Fatal (Y/N):</p><p>If Yes, Name, Address and Relationship of Nearest Relative:</p><p>Last Date Paid in Full:</p><p><b>Virginia</b></p><p>Returned to work (Y/N): If Yes, at what Wage \$:</p><p>Federal Tax ID Number:</p><p><b>Washington</b> - No Additional State Questions</p><p><b>West Virginia</b></p><p>Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)</p><p><b>Wisconsin</b> - No Additional State Questions</p><p><b>Wyoming</b> - No Additional State Questions</p><p><b>U.S. Longshoreman (USDOL)</b> - No Additional State Questions</p></td></tr>	<p><b>Rhode Island</b></p> <p>Federal ID Number:</p> <p>First Full Day Lost from work:</p> <p>Unemployment Insurance Number:</p> <p>State of Hire:</p> <p>Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):</p> <p>If Yes, Date Employer first Notified of medical treatment or lost time:</p> <p>Category of Injury or Illness ("X" all that apply):</p> <p>Injury: Illness: Occupational Disease: Repetitive Trauma: Occupational Hearing Loss: Unknown:</p> <p><b>South Carolina</b> - No Additional State Questions</p> <p><b>South Dakota</b></p> <p>Federal ID Number:</p> <p>Number of employees:</p> <p>Body Part Injured Code (2 digits):</p> <p>Cause of Injury Code (2 digits):</p> <p>Nature of Injury Code (2 digits):</p> <p>Was employee hired for temporary employment (Y/N):</p> <p>Carrier Code:</p> <p><b>Tennessee</b> - No Additional State Questions</p> <p><b>Texas</b> - No Additional State Questions</p> <p><b>Utah</b> - No Additional State Questions</p> <p><b>Vermont</b></p> <p>Federal ID Number:</p> <p>Was employee hired in Vermont (Y/N):</p> <p>Does the employer regularly employ 10 or more employees (Y/N):</p> <p>Returned to work (Y/N): If Yes, at what Weekly Wage \$:</p> <p>Was injured paid in full for the date disability began (Y/N):</p> <p>Was employee injured at his/her regular occupation (Y/N):</p> <p>Fatal (Y/N):</p> <p>If Yes, Name, Address and Relationship of Nearest Relative:</p> <p>Last Date Paid in Full:</p> <p><b>Virginia</b></p> <p>Returned to work (Y/N): If Yes, at what Wage \$:</p> <p>Federal Tax ID Number:</p> <p><b>Washington</b> - No Additional State Questions</p> <p><b>West Virginia</b></p> <p>Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)</p> <p><b>Wisconsin</b> - No Additional State Questions</p> <p><b>Wyoming</b> - No Additional State Questions</p> <p><b>U.S. Longshoreman (USDOL)</b> - No Additional State Questions</p>
<p><b>Rhode Island</b></p> <p>Federal ID Number:</p> <p>First Full Day Lost from work:</p> <p>Unemployment Insurance Number:</p> <p>State of Hire:</p> <p>Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):</p> <p>If Yes, Date Employer first Notified of medical treatment or lost time:</p> <p>Category of Injury or Illness ("X" all that apply):</p> <p>Injury: Illness: Occupational Disease: Repetitive Trauma: Occupational Hearing Loss: Unknown:</p> <p><b>South Carolina</b> - No Additional State Questions</p> <p><b>South Dakota</b></p> <p>Federal ID Number:</p> <p>Number of employees:</p> <p>Body Part Injured Code (2 digits):</p> <p>Cause of Injury Code (2 digits):</p> <p>Nature of Injury Code (2 digits):</p> <p>Was employee hired for temporary employment (Y/N):</p> <p>Carrier Code:</p> <p><b>Tennessee</b> - No Additional State Questions</p> <p><b>Texas</b> - No Additional State Questions</p> <p><b>Utah</b> - No Additional State Questions</p> <p><b>Vermont</b></p> <p>Federal ID Number:</p> <p>Was employee hired in Vermont (Y/N):</p> <p>Does the employer regularly employ 10 or more employees (Y/N):</p> <p>Returned to work (Y/N): If Yes, at what Weekly Wage \$:</p> <p>Was injured paid in full for the date disability began (Y/N):</p> <p>Was employee injured at his/her regular occupation (Y/N):</p> <p>Fatal (Y/N):</p> <p>If Yes, Name, Address and Relationship of Nearest Relative:</p> <p>Last Date Paid in Full:</p> <p><b>Virginia</b></p> <p>Returned to work (Y/N): If Yes, at what Wage \$:</p> <p>Federal Tax ID Number:</p> <p><b>Washington</b> - No Additional State Questions</p> <p><b>West Virginia</b></p> <p>Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)</p> <p><b>Wisconsin</b> - No Additional State Questions</p> <p><b>Wyoming</b> - No Additional State Questions</p> <p><b>U.S. Longshoreman (USDOL)</b> - No Additional State Questions</p>	

## IMPORTANT INFORMATION TO VIRGINIA POLICYHOLDERS

In the event you need to contact someone about this policy for any reason, please contact your agent. If you have additional questions, you may contact the Travelers office checked below:

\_\_\_\_\_ Richmond CAM Office  
30 Arboretum Place  
Richmond, VA 23236  
(804) 330-6000

\_\_\_\_\_ Falls Church CAM Office  
3110 Fairview Park Drive  
Falls Church, VA 220442  
(703) 641-7500

\_\_\_\_\_ The Travelers Home Office  
(Property-Casualty 10 Main North)  
One Tower Square  
Hartford, CT 06183

\_\_\_\_\_ Property (860) 277-7361

\_\_\_\_\_ Casualty (860) 277-3714

For Assistance, ask for:  A SAM Marketing Representative  
 A CAD Marketing Representative  
 A CAM Marketing Representative

If you have been unable to contact or obtain satisfaction from TheTravelers or your agent, you may contact the Virginia Bureau of Insurance:

Property and Casualty Division  
P.O. Box 1157  
Richmond, VA 23209

In state, toll-free: 1-800-552-7954  
Out of state, toll-free: 1-804-786-3741



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## PRIVACY NOTICE

THE TRAVELERS INSURANCE COMPANIES

### PRIVACY POLICY

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

#### Collection Of Information

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

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

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

#### Disclosure Of Information

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

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

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

### **Confidentiality And Security**

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

### **Disclosure and Protection of Former Customers' Information**

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

### **Changes In Privacy Policy**

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

## **IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION**

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

For information about how Travelers compensates independent agents and brokers, please visit [www.travelers.com](http://www.travelers.com), call our toll-free telephone number 1-866-904-8348, or request a written copy from Marketing at One Tower Square, 2GSA, Hartford, CT 06183.



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## **IMPORTANT Policy Audit Information**

Dear Policyholder:

This policy is issued with an estimated premium based upon information provided through your Producer. This premium is subject to adjustment at the end of the policy period. At that time, you may receive a request for information in the mail or a premium auditor may contact you to review the necessary records. The information developed is needed to determine the final earned premium for this policy.

## Record Maintenance

In order to facilitate audit service, it is necessary to maintain proper records and have them available at the proper time. Based on the nature of your business, some of the following data will be necessary to complete the audit:

1. General Ledger, Financial Statements
  2. Payroll Records, Time Books, State Unemployment Returns, FICA Returns, Individual Earnings Records-Monthly totals separated by type of work and overtime.
  3. Cash Receipts, Sales Journal
  4. Cash Disbursements Journal - Including subcontractors, casual labor and material costs.
  5. Certificates of Insurance

**IMPORTANT COVERAGE NOTE:**

If you utilize subcontractors whose legal status is that of sole proprietor/partner, we may charge premium for these persons as provided under Part 5 of the policy contract even though certificates of insurance may exist. Please contact your producer if you have any questions regarding your Workers' Compensation coverage needs.

### Work in Other States

Please advise your Producer if employees are hired for work in states other than those listed in Item 3. of your policy. This will enable your producer to consider your need for coverage in accordance with state laws.

We appreciate the opportunity to serve you. If you have any questions about the enclosed policy or any insurance matters please contact your producer or your Company representative.



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## ALASKA

## NOTICE TO INSURED

Dear Policyholder:

This is to notify you that your Workers' Compensation and Employers Liability policy does not provide Other States Coverage for the State of Alaska.

If you have operations or start up an operation in Alaska, and it is not listed in Item 3A of the Information Page, you or your agent must notify us and request that this state be covered under your policy.

With receipt of your request for coverage, we will extend the policy to include this state.

Your Agent can provide you with necessary information and will assist you in obtaining coverage for this state.



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## POLICYHOLDER NOTICE

### CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

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

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

### CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.
4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.
6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.
  - (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code Section 11750.3(c).
  - (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

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

## POLICYHOLDER NOTICE

### YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

#### I. INFORMATION AVAILABLE TO YOU

##### A. Information Available from Us The Travelers Companies

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

**TRAVELERS**  
 P.O. Box 6512  
 21688 Gateway Center Drive  
 Diamond Bar, CA 91765  
 Phone: 1-909-612-3609  
 Fax: 1-909-612-3629  
 Website: [www.travelers.com](http://www.travelers.com)

- (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* (USR) 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.wcirb.com>. The regulations contained in the USR 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 <http://www.wcirb.com/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.

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

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:

#### TRAVELERS

11090 White Rock Road  
Rancho Cordova, CA 95670-6001

Phone: 1-800-328-2189

Website: [www.Travelers.com](http://www.Travelers.com)

#### TRAVELERS

P.O. Box 6512  
21688 Gateway Center Drive  
Diamond Bar, CA 91765

Phone: 1-909-612-3609  
Fax: 1-909-612-3629

Website: [www.Travelers.com](http://www.Travelers.com)

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, Section 2509.40 et seq. You must file your appeal within 30 days after we or the WCIRB send you the notice rejecting review of your Complaint and Request for Action or the decision upon your Complaint and Request for Action. If no written decision regarding your Complaint and Request for Action is sent, your appeal must be filed within 120 days after you sent your Complaint and Request for Action to us or to the WCIRB. The filing address for all appeals to the insurance commissioner is:

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

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

### III. RESOURCES AVAILABLE TO YOU IN OBTAINING INFORMATION AND PURSUING DISPUTES

**A. Policyholder Ombudsman.** Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the insurance commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 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 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.



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## Your Workers' Compensation Benefits – California

*This form should be given to all newly hired employees in the State of California. Its content applies to industrial injuries on or after January 1, 2013.*

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

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job, or are a victim of a workplace crime. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures to a harmful condition (such as hurting your wrist from doing the same motion over and over).

**Workers' compensation benefits include:**

**Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. Physical therapy, occupational therapy and chiropractic visits may be limited to 24 each.

**Temporary Disability Benefits:** Payments if you lose wages while recovering. For most injuries after April 18, 2004, temporary disability benefits are limited to 104 weeks within 5 years from your date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TTD benefits are terminated, delayed or denied.

**Permanent Disability Benefits:** Payments if your injury causes a permanent disability. Once your injury stabilizes, your treating physician may find permanent disability, depending upon your level of recovery. The amount of permanent disability found by your doctor will be rated by your claims administrator according to your age and occupation in order to determine the percentage and corresponding dollar amount of permanent disability due. These amounts are set by state law. You have the right to obtain a state disability rating or appeal a rating.

**Return to Work Program:** If you experience a permanent earnings loss as a result of your injury and your permanent disability benefits are determined to be disproportionately low, you may qualify for additional monies from the Department of Industrial Relation's Return to Work Fund. Contact the Department of Industrial Relations at: [www.dir.ca.gov/](http://www.dir.ca.gov/) to learn more about this additional benefit.

**Supplemental Job Displacement Vouchers:** If your injury causes you to miss time from work and results in permanent disability, you may receive a supplemental job displacement voucher if your employer has not offered modified, alternative or regular employment within 60 days of receipt of the doctor's medical report indicating you have made a maximum medical recovery. The voucher is for reimbursement of education-related costs and is capped at \$6,000.00. If you receive a voucher as a result of your injury, you have two years from the date you are furnished the voucher or five years from your date of injury (whichever occurs later), to request reimbursement for qualifying expenditures.

**Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness. Burial expenses are also provided, with the maximum amount allowed dependent upon the date of injury.

Temporary disability, permanent disability, and death benefits are all payable at a rate based on 2/3 of your average weekly wage, and subject to state minimum and maximum amounts in effect on your date of injury. These benefits are paid every two weeks while you are eligible.

**Voluntary, off duty, recreational, social or athletic activities may not be covered under workers' compensation.**

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This form complies with Labor Code requirements §3551, §3553, and Administrative Rule §9880, and has been approved by the Administrative Director of the Division of Workers' Compensation. This form cannot be altered.

**If you get hurt:**

**Get Medical Care.** If you need first aid, contact your employer. If you need emergency care, call for help immediately.

**Report Your Injury.** Report the injury immediately to your supervisor. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury, and must also authorize treatment within one working day after you have returned a signed and completed copy of the form. The statute of limitations for filing a workers' compensation claim is one year from the date of injury or, if resulting from repeated exposures, one year from when you realized or should have realized that your job caused the injury.

**See Your Treating Physician.** Your primary treating physician is the doctor with overall responsibility for treating your injury or illness. He or she is charged with maintaining the continuity of your care, as well as initiating referrals to specialists. If your employer has an approved Medical Provider Network (MPN), they may be able to limit your choices of treating physicians retain medical control, and require you to treat with an MPN physician from the onset. (An MPN is a selected network of healthcare providers who provide treatment to workers injured on the job. See your employer for more information on your MPN.) Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If your employer does not have an approved MPN and you wish to change doctors in the first 30 days after reporting your claim, your claims administrator must select a new physician within five days of your request.

If you have provided your employer with the name of your personal physician before your injury and have group health insurance at the time of injury, you may see your personal physician for treatment even if your employer has an approved MPN. Your personal physician must be a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, or multi-specialty medical group of doctors of medicine or osteopathy, and must have treated you and maintained your medical history and records before your work injury and must also agree to treat you for a work-related injury or illness. If your employer does not have an approved MPN and you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request. If you still need medical care after 30 days, you may be able to switch to a doctor of your own choice.

For your convenience, optional forms to predesignate your personal physician or multi-specialty medical group of doctors of medicine or osteopathy are attached to this document. Also attached, are forms to predesignate your personal acupuncturist or chiropractor if your employer does not have a medical provider network in place. By law, chiropractors are not allowed to be the treating physician after 24 visits.

**Discrimination:** It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If your employer has been found to discriminate, you may be entitled to job reinstatement with back pay, increased compensation, and costs and expenses. You may also have additional rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-3362. You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401** or learn more online at: <http://www.dir.ca.gov>.

If medical care is not being provided by your employer you have several options. First, contact your claims administrator to find out the status of your claim. If you have given your employer a completed and signed claim form but your claim has been delayed for investigation, your employer is still required to authorize treatment, up to \$10,000.00, during the delay. If the claim has not been accepted yet and your medical costs have exceeded the statutory \$10,000.00 cap, you can go to your group health plan for care, find a doctor, clinic or hospital that will bill the claims administrator directly, or use public health services.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it.

Your Workers' Compensation Insurance Company is Travelers Property Casualty Company of America.

You can also look up your insurance carrier at the WCIRB online lookup: <https://www.caworkcompcov.com/>

You can obtain free information from an Information and Assistance Officer of the state Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. A list of Information and Assistance offices can be found at the end of this pamphlet to help you locate the I&A office nearest you. You may also go to the DWC web site at: <http://www.dir.ca.gov> for further information.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at: <http://www.californiaspecialist.org>. You may get a list of attorneys from your local information and assistance officer or look in your yellow pages.



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This form complies with Labor Code requirements §3551, §3553, and Administrative Rule §9880, and has been approved by the Administrative Director of the Division of Workers' Compensation. This form cannot be altered.

### **Predesignation of personal physician**

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- you have group health coverage at the time of injury;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

### **Notice of predesignation of personal physician**

**Employee: Complete this section.**

To: \_\_\_\_\_ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_ (Name of Doctor, M.D., D.O., or medical group)

\_\_\_\_\_ (Street address, city, state, zip code)

\_\_\_\_\_ (Telephone number)

Employee Name (please print): \_\_\_\_\_

Employee's Address: \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: I agree to this Predesignation:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Physician or designated employee of the physician or medical group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

**Notice of personal chiropractor or personal acupuncturist**

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist. By law, chiropractors are not allowed to be the treating physician after 24 visits.

### Your Chiropractor or Acupuncturist's Information:

(Name of chiropractor or acupuncturist)

(Street address, city, state, zip code)

(Telephone Number)

Employee Name (please print): \_\_\_\_\_

Employee Address \_\_\_\_\_

Employee's Signature \_\_\_\_\_

Date: \_\_\_\_\_



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This form complies with Labor Code requirements §3551, §3553, and Administrative Rule §9880, and has been approved by the Administrative Director of the Division of Workers' Compensation. This form cannot be altered.

**Contact the information & assistance unit:**

- By phone at 1-800-736-7401 – For recorded information that helps injured workers, employers and others understand California's workers compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

<b>Anaheim</b> 1065 N. PacifiCenter Drive Anaheim 92806 (714) 414-1801	<b>Oakland</b> 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	<b>San Diego</b> 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082
<b>Bakersfield</b> 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	<b>Oxnard</b> 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	<b>San Francisco</b> 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
<b>Eureka</b> 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	<b>Pomona</b> 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	<b>San Jose</b> 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292
<b>Fresno</b> 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	<b>Redding</b> 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047	<b>San Luis Obispo</b> 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
<b>Goleta</b> 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158	<b>Riverside</b> 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	<b>Santa Ana</b> 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597
<b>Long Beach</b> 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	<b>Sacramento</b> 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	<b>Santa Rosa</b> 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
<b>Los Angeles</b> 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	<b>Salinas</b> 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	<b>Stockton</b> 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
<b>Marina del Rey</b> 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	<b>San Bernardino</b> 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	<b>Van Nuys</b> 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

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## Sus Beneficios de compensación laboral – California

**Este formulario debe entregarse a todos los empleados recién contratados en el estado de California. Su contenido se aplica a los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.**

**Cualquier persona que haga o propicie que se haga cualquier declaración sustancial a sabiendas falsa o fraudulenta con el propósito de obtener o denegar beneficios o pagos de compensación laboral es culpable de un delito.**

Usted puede tener derecho a beneficios de compensación laboral si resulta lesionado o se enferma a causa de su trabajo, o si es víctima de un delito en el lugar de trabajo. La compensación laboral cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un acontecimiento (como lastimarse la espalda en una caída) o por exposiciones repetidas a una circunstancia perjudicial (como lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

### **Los beneficios de compensación laboral incluyen:**

**Atención médica:** consultas médicas, servicios hospitalarios, fisioterapia, análisis de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar su lesión. No debe recibir nunca una factura. Es posible que las visitas para fisioterapia, terapia ocupacional y al quiropráctico tengan un límite de 24 visitas para cada tipo.

**Beneficios por incapacidad temporal:** Pagos si usted deja de recibir su salario mientras se recupera. Para la mayoría de las lesiones ocurridas después del 18 de abril de 2004, los beneficios por incapacidad temporal se limitan a 104 semanas dentro del lapso de 5 años a partir de la fecha de la lesión. Presentar de forma oportuna una reclamación en el Departamento de Desarrollo Laboral (Employment Development Department) puede conducir a la obtención de beneficios estatales adicionales por incapacidad cuando se terminan los beneficios por incapacidad total temporal (TTD, por sus siglas en inglés), o cuando estos se demoran o los deniegan.

**Beneficios por incapacidad permanente:** Pagos si su lesión causa una incapacidad permanente. Una vez que su lesión se estabilice, es posible que el médico que lo trata determine que usted tiene una incapacidad permanente, dependiendo de su grado de recuperación. La cantidad de incapacidad permanente que su médico determine será clasificada por su administrador de reclamaciones según su edad y ocupación con el fin de determinar el porcentaje y la cantidad correspondiente en dólares que se le debe a usted a causa de la incapacidad permanente. La ley estatal establece dichas cantidades. Usted tiene derecho a obtener una clasificación estatal de incapacidad o a apelar la clasificación.

**Programa para reintegrarse al trabajo:** Si usted sufre la pérdida permanente de sus ingresos como resultado de su lesión y se determina que sus beneficios por incapacidad permanente son desproporcionadamente bajos, es posible que usted califique para recibir dinero adicional del Fondo para la reintegración al trabajo del Departamento de Relaciones Laborales (Department of Industrial Relations). Comuníquese con el Departamento de Relaciones Laborales en: [www.dir.ca.gov/](http://www.dir.ca.gov/) para conocer más acerca de este beneficio adicional.

**Vales suplementarios por destitución laboral:** Si su lesión conlleva a que usted falte a su trabajo y le causa una incapacidad permanente, usted puede recibir un vale suplementario por destitución laboral si su empleador no le ofrece un empleo modificado, alternativo o regular dentro de 60 días de haber recibido el informe médico que indique que usted logró una recuperación médica máxima. El vale es para reembolsar los costos educativos y tiene un límite de \$6,000.00. Si usted recibe un vale como consecuencia de su lesión, tiene dos años desde la fecha en que le proporcionen el vale o cinco años desde la fecha de su lesión (lo que ocurra último), para solicitar el reembolso de los gastos que califiquen.

**Beneficios por muerte:** Se pagan a los dependientes de un trabajador que muere a causa de una lesión o enfermedad laboral. También se cubren los gastos del entierro; la cantidad máxima permitida depende de la fecha de la lesión.

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Los beneficios por incapacidad temporal, incapacidad permanente y muerte se pagan a una tasa basada en 2/3 de su salario semanal promedio, y están sujetos a las cantidades mínimas y máximas vigentes en el estado en la fecha de su lesión. Estos beneficios se pagan cada dos semanas mientras usted sea elegible.

**Es posible que las actividades como voluntario, en sus horas libres, recreacionales, sociales o atléticas no estén cubiertas bajo la compensación laboral.**

**Si se lastima:**

**Obtenga atención médica.** Si necesita primeros auxilios, comuníquese con su empleador. Si necesita atención urgente, pida ayuda de inmediato.

**Informe sobre su lesión.** Informe de inmediato a su supervisor sobre su lesión. No demore en hacerlo; existen límites de tiempo. Si espera demasiado, puede perder los derechos que tiene a recibir beneficios. Su empleador tiene que proporcionarle un formulario de reclamación a más tardar un día laborable después de que esté enterado de su lesión, y también debe autorizar el tratamiento a más tardar un día laborable después de que usted le entregue una copia del formulario lleno y firmado. El plazo de prescripción para presentar una reclamación de compensación laboral es de un año a partir de la fecha de la lesión o, si esta se debe a exposiciones repetidas, un año a partir del momento en que usted se dio cuenta o debió darse cuenta de que su trabajo causó la lesión.

**Vea a su médico tratante.** Su médico tratante primario es el médico con la responsabilidad global de tratar su lesión o enfermedad. Él o ella están a cargo de mantener la continuidad de su atención, así como de remitirlo a los especialistas. Si su empleador tiene una Red de Proveedores Médicos (MPN, por sus siglas en inglés) aprobada, es posible que ellos puedan limitar sus opciones de médicos tratantes, que retengan el control médico, y que le exijan que se atienda con un médico de la MPN desde el principio. (Una MPN es una red escogida de proveedores de atención médica que proveen tratamiento a los empleados que se lesionan en el trabajo. Consulte con su empleador para obtener más información sobre su MPN). De lo contrario, su empleador tiene el derecho de escoger el médico que lo tratará a usted por los primeros 30 días. Si su empleador no tiene una MPN aprobada y usted desea cambiar de médico en los primeros 30 días después de presentar su reclamación, su administrador de reclamaciones debe escoger un médico nuevo en un lapso de cinco días después de que usted lo solicite.

Si usted le proporcionó a su empleador el nombre de su médico personal antes de sufrir la lesión y tiene seguro médico de grupo al momento de la lesión, usted puede tratarse con su médico personal incluso si su empleador tiene una MPN aprobada. Su médico personal debe ser un médico general o un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, o un grupo médico con múltiples especialidades con doctores o licenciados en medicina, y debe haberlo tratado y tener sus antecedentes médicos y su historia clínica antes de su lesión laboral y también debe estar de acuerdo en tratarlo por una lesión o enfermedad laboral. Si su empleador no tiene una MPN aprobada y usted le dio a su empleador por escrito el nombre de su quiropráctico o acupunturista personal antes de sufrir la lesión, usted puede cambiarse al quiropráctico o acupunturista cuando lo solicite. Si todavía necesita recibir atención médica luego de 30 días, quizás pueda cambiarse a un médico de su propia elección.

Para mayor comodidad, se adjuntan a este documento formularios opcionales para predesignar a su médico personal o a un grupo médico con múltiples especialidades con doctores o licenciados en medicina. También se adjuntan formularios para predesignar a su acupunturista o quiropráctico personal si su empleador no cuenta con una red de proveedores médicos. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

**Discriminación:** Es ilegal que su empleador lo castigue o lo despida por sufrir una lesión o enfermedad laboral, por presentar una reclamación, o por testificar en el caso de compensación laboral de otra persona. Si se determina que su empleador ha cometido discriminación, usted puede tener derecho a que se le reincorpore a su puesto de trabajo con pagos retroactivos, una mayor compensación, y costos y gastos. Es posible que usted tenga otros derechos bajo la Ley de Protección para Personas Discapacitadas (ADA, por sus siglas en inglés) o la Ley de Igualdad en el Empleo y la Vivienda (FEHA, por sus siglas en inglés). Para obtener más información, comuníquese con FEHA al (800) 884-1684 o con la Comisión de Igualdad de Oportunidades Laborales (EEOC,

por sus siglas en inglés) al (800) 669-3362. Puede obtener información gratuita de un funcionario de información y ayuda de la División de Compensación Laboral de su estado. Puede escuchar información grabada y una lista de las oficinas locales llamando sin costo al (800) 736-7401 o averiguar más en línea en: <http://www.dir.ca.gov>.

Si su empleador no le proporciona atención médica, usted tiene varias opciones. Primero, comuníquese con su administrador de reclamaciones para averiguar el estado de su reclamación. Si le entregó a su empleador un formulario de reclamación lleno y firmado pero su reclamación está retrasada por la investigación, su empleador tiene que autorizar el tratamiento, hasta un máximo de \$10,000.00, durante el retraso. Si todavía no se ha aceptado la reclamación y sus costos médicos sobrepasan el límite reglamentario de \$10,000.00, usted puede acudir a su plan médico de grupo para recibir atención, buscar un médico, una clínica o un hospital que le facture directamente al administrador de reclamaciones, o utilizar los servicios públicos de atención médica.

Usted tiene derecho a estar en desacuerdo con las decisiones que afectan su reclamación. Si está en desacuerdo, comuníquese primero con su administrador de reclamaciones para ver si lo pueden resolver.

Su compañía de seguros de compensación laboral es **Travelers Property Casualty Company of America**.

También puede buscar su compañía de seguros en el directorio en línea de WCIRB: <https://www.caworkcompcovrage.com/>

Puede obtener información gratuita de un funcionario de Información y Ayuda de la División de Compensación Laboral de su estado, o puede escuchar información grabada y una lista de las oficinas locales llamando al (800) 736-7401. Al final de este folleto, encontrará una lista de las oficinas de Información y Ayuda. Esto lo ayudará a localizar la oficina más cerca de usted. Para más información, también puede visitar el sitio web del DWC en: <http://www.dir.ca.gov>.

Puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar un abogado, es posible que los honorarios se saquen de algunos de sus beneficios. Para obtener los nombres de los abogados especializados en compensación laboral, llame al Colegio de Abogados del estado de California al (415) 538-2120 o visite su sitio web en: <http://www.californiaspecialist.org>. El funcionario local de información y ayuda puede proporcionarle una lista de los abogados o usted puede buscarlos en las páginas amarillas.



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## **Predesignación del médico personal**

En caso de que sufra una lesión o enfermedad relacionada con su empleo, su médico (doctor (M.D.) o licenciado (D.O.) en medicina) personal o grupo médico pueden atenderlo si:

- usted tiene cobertura médica de grupo al momento de la lesión;
- el médico es su médico habitual, y debe ser un médico cuyo ejercicio de la medicina se limita a medicina general o que es un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, y que anteriormente haya estado a cargo de su tratamiento médico y tenga en su poder su historia clínica;
- su "médico personal" puede ser un grupo médico si se trata de una corporación con un solo miembro o una sociedad constituida por doctores o licenciados en medicina, que opere un grupo médico integrado con múltiples especialidades que brinde servicios médicos integrales predominantemente para enfermedades y lesiones que no sean de tipo laboral;
- antes de la lesión, su médico acepta tratarlo por lesiones o enfermedades laborales;
- antes de la lesión, usted le proporcionó a su empleador lo siguiente por escrito: (1) notificación de que usted desea que su médico personal lo trate por lesiones o enfermedades laborales, y (2) el nombre y la dirección del consultorio de su médico personal.

Puede usar este formulario para notificar a su empleador si desea que su médico o licenciado en medicina personal lo trate por una lesión o enfermedad laboral, siempre que se cumplan los requisitos anteriores.

### **Notificación de predesignación del médico personal**

**Empleado: Llene esta sección.**

Para: \_\_\_\_\_ (nombre del empleador) Si sufro una lesión o enfermedad laboral,  
escojo ser atendido por:

(Nombre del médico, doctor en medicina, licenciado en medicina o grupo médico)

(Dirección, ciudad, estado, código postal)

(Número de teléfono) \_\_\_\_\_

Nombre del empleado (en letra de imprenta): \_\_\_\_\_

Dirección del empleado: \_\_\_\_\_

Firma del empleado \_\_\_\_\_ Fecha: \_\_\_\_\_

**Médico: Estoy de acuerdo con esta predesignación.**

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_  
(Médico o empleado designado del médico o del grupo médico)

No se requiere que el médico firme este formulario, sin embargo, si el médico o el empleado designado del médico o del grupo médico no firma, se necesitará otra documentación de la aceptación del médico a ser predesignado, conforme al Capítulo 8, Código de Disposiciones Reglamentarias de California, apartado 9780.1(a)(3).



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### **Notificación de quiropráctico personal o acupunturista personal**

Si su empleador o la compañía de seguros de su empleador no tienen una Red de Proveedores Médicos, usted quizás pueda cambiar su médico tratante a su quiropráctico o acupunturista personal después de una lesión o enfermedad laboral. Para cumplir los requisitos para hacer este cambio, debe proporcionarle a su empleador, por escrito, el nombre y la dirección del consultorio de un quiropráctico o acupunturista personal antes de que ocurra la lesión o enfermedad. Por lo general, su administrador de reclamaciones tiene el derecho de escoger su médico tratante dentro de los primeros 30 días después de que su empleador esté enterado de su lesión o enfermedad. Luego de que su administrador de reclamaciones inicie su tratamiento con otro médico durante este período, usted podrá, previa solicitud, hacer que transfieran su tratamiento a su quiropráctico o acupunturista personal.

Usted puede utilizar este formulario para notificar a su empleador acerca de su quiropráctico o acupunturista personal. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

#### **Información de su quiropráctico o acupunturista:**

(Nombre del quiropráctico o acupunturista)

(Dirección, ciudad, estado, código postal)

(Número de teléfono)

Nombre del empleado (en letra de imprenta): \_\_\_\_\_

Dirección del empleado: \_\_\_\_\_

Firma del empleado \_\_\_\_\_ Fecha: \_\_\_\_\_

**Comuníquese con la unidad de información y ayuda**

- Por teléfono al 1-800-736-7401: Para obtener información grabada que ayuda a los trabajadores lesionados, los empleadores y otras personas a entender el sistema de compensación laboral de California, y sus derechos y responsabilidades conforme a la ley.
- Asistiendo a un taller para trabajadores lesionados
- Llamando o yendo en persona a una oficina local de la Unidad de información y ayuda:

<b>Anaheim</b> 1065 N. Pacific Center Drive Anaheim 92806 (714) 414-1801	<b>Oakland</b> 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	<b>San Diego</b> 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082
<b>Bakersfield</b> 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	<b>Oxnard</b> 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	<b>San Francisco</b> 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
<b>Eureka</b> 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	<b>Pomona</b> 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	<b>San Jose</b> 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292
<b>Fresno</b> 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	<b>Redding</b> 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047	<b>San Luis Obispo</b> 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
<b>Goleta</b> 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158	<b>Riverside</b> 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	<b>Santa Ana</b> 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597
<b>Long Beach</b> 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	<b>Sacramento</b> 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	<b>Santa Rosa</b> 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
<b>Los Angeles</b> 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	<b>Salinas</b> 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	<b>Stockton</b> 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
<b>Marina del Rey</b> 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	<b>San Bernardino</b> 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	<b>Van Nuys</b> 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

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## **POLICYHOLDER NOTICE**

### **JANUARY 1, 2014 AUDIT REQUIREMENTS FOR POLICIES WITH FINAL PREMIUM OF LESS THAN \$10,000 THAT DEVELOP PAYROLL IN HIGH WAGE DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS**

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

If your policy effective on or after January 1, 2014 produces a final premium of less than \$10,000 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. If your policy produces a final premium of \$10,000 or more, a physical audit is required at least once a year.

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





**STATE OF CALIFORNIA**  
**IMPORTANT LOSS CONTROL INFORMATION**

The Loss Control Services outlined in the enclosed Safety Services notice are available at no additional cost to you.

Workers' Compensation insurance policyholders may register comments about the insurer's loss control consultation services by writing to: State of California, Department of Industrial Relations, Division of Occupational Safety and Health, P.O. Box 420603, San Francisco, CA 94142.



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## **POLICYHOLDER NOTICE**

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

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

## **Payroll Record Requirements**

The assignment of a high wage classification to any non-salaried employee is contingent on verifying that employee's hourly wage by reconciling the total number of hours the employee actually worked throughout 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. Recording the start and stop times for a uniform unpaid meal period at job locations where all operations cease for the uniform break period is not required.

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

## Audit Requirements

If your policy produces a final premium of \$10,000 or more, a physical audit is required at least once a year. If your policy produces a final premium of less than \$10,000 and payroll is developed under a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

If you hold a C-39 Roofing Contractor license from the California Contractors State License Board, a physical audit is required on the complete policy period of each policy regardless of the amount of final premium.







# FLORIDA

## *Workers Compensation*

# Managed Care

# Arrangement

# Handbook

### Inside:

- Employer/Employee Implementation Guides
- Program Explanation for Employees
- Employee Questions and Answers
- Employee Satisfaction Survey
- Employee Rights & Responsibilities and Grievance Policy
- Acknowledgment Form

**Employee Rights & Responsibilities and the Grievance Policy and Grievance form are to be shared with each employee. The other informative materials can be used at your discretion.**

## **Florida Workers Compensation Managed Care Arrangement**

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### **To our Employers:**

Thank you for taking an active role in helping manage your Workers Compensation exposures. The enclosed information is designed to give you basic knowledge of your Workers Compensation Managed Care Arrangement ("WC/MCA"). By taking an active role in ensuring the use of the WC/MCA, you may be able to expedite medical recovery for your injured employees and reduce lost time days.

Your Carrier/Claim Administrator has contracted with Coventry Health Care Workers' Compensation, Inc. for the use of their Coventry Integrated Network ("Network") of medical providers to ensure high quality medical care related to workers compensation claims. Providers within the Network are experienced in Workers Compensation, and have contractually agreed to comply with Florida Workers Compensation Law.

To maximize the benefits of the WC/MCA, pre-injury preparation should include the following:

1. Identify which Network PCPs are available near your work-site by reviewing the on-line directory. (The Network search engine is available through [www.travelers.com](http://www.travelers.com) or [www.mywcinfo.com](http://www.mywcinfo.com))
2. Select one or more of the nearby PCPs and initiate a working relationship with them. Doing so in advance will make it quick and easy to refer an Employee should a work-site injury occur. Consider posting the list of PCPs (with addresses and phone numbers) in a location easily accessible to those employees who will use it should an injury occur.
3. Make your staff familiar with the provider listings and explain how easy it is to use providers in the Network Directory.
4. Advise the staff that use of the network providers is mandatory except in emergency situations. The providers participating in the Network meet specific quality standards and credentials and are experienced in treating work-related injuries and illnesses.
5. For employees who have Internet access, use of the [www.mywcinfo.com](http://www.mywcinfo.com) web page can provide additional access to selection of network providers. However, employees need to know that only treatment that is authorized by the carrier will be compensable in the Workers Compensation claim.
6. It is in everyone's best interest to return your Employee to the job as soon as it is medically appropriate. The availability of modified and/or transitional duty programs at the work-site is key to this approach. Designate a company employee to serve as your Workers Compensation Coordinator and develop a transitional duty program.

To assist with implementation of the WC/MCA, this packet includes the following materials for your use:

1. How to Locate a Network Primary Care Provider on the Travelers' Internet Site
2. What To Do When An Employee Reports An Injury
3. Request For Medical Treatment Form
4. Sample Letter To The Employee
5. Questions and Answers for Employees
6. Employee Satisfaction Survey
7. Employees Rights & Responsibilities
8. Employee Grievance Procedure

If you have any questions concerning the enclosed materials, or if additional resources are needed, please do not hesitate to call the Managed Care Administrator at 1-800-842-6771. Your active role can produce better outcomes for everyone involved in the Workers Compensation process.

**How To Locate a Network Primary Care Provider on the Travelers Internet Site**

Travelers Internet site is: [www.travelers.com](http://www.travelers.com)

*Select:*

- "Workers Comp Claim Resources" under Claim
- "Find a Network Medical Provider" under Workers Comp Claim Resources

You are now in the Workers Compensation Network provider search engine:

- Select "Provider Search"

A screen appears that allows you to set your search parameters

- Enter the zip code for the usual employment site for the employee/employer
- Select the mileage range, up to 20 miles for Primary Care Physicians
- Allow the "Sort Results By" category to remain set at "Distance"
- Select the Number of provider matches you would like to see on each page
- Click on "Continue"
- On the new screen, click on/highlight the "Provider Types" and/or "Specialties" you would like to include in the search
- Click on "Find Providers"
- Scroll down the page to find a list of Network providers. Depending on the geographic distance, there may be several pages of physicians provided.

You can generate a printed list or directory of Network physicians using several methods:

- At the end of the page, click on "Create Provider Listing" button. This will create a listing of all the providers on that page.
- At the end of the list of physicians on a given page there are 2 buttons. Click on "Select all providers on this page." A check mark will appear before all providers. Click on the "Create Provider Listing" button and a directory will be generated.
- If you would like a short list of physicians/providers, click in the box before each provider you would like to select on that page. Then click on "Create Provider Listing" and a list of your selected physicians will be available for printing.
- A directory for the entire state of Florida can be obtained by clicking on the tab at the top of the screen, labeled "Directories."

More about the provider database:

- Obtain additional information about a specific provider by clicking on the map icon. You will find more information about the provider, a location map and a tool to gain driving instructions.



**WHAT TO DO WHEN AN EMPLOYEE REPORTS AN INJURY**

When emergency medical attention is required, send the injured employee to the nearest medical facility and contact the telephone reporting center at 1-800-832-7839 to report the claim.

When an employee reports an injury not requiring emergency treatment, the following steps should be observed:

**1. GATHER INFORMATION REGARDING THE INJURY**

Ask the injured employee how, when and where the injury occurred, and if there were any witnesses.

**2. CONTACT TELEPHONE REPORTING CENTER AT 1-800-832-7839 TO REPORT THE CLAIM**

Upon direction from the Claim Adjuster, send the injured employee for medical treatment. Remember: If this is a medical emergency, direct the employee to seek medical attention immediately and then follow-up with this call.

**3. DIRECT THE INJURED EMPLOYEE TO CHOOSE A PRIMARY CARE PHYSICIAN.**

In non-emergency situations, if the employee appears to need medical attention, either direct the employee to the Network Primary Care Physician ("PCP") of your choice, or instruct the employee to choose a PCP from your list of providers within the Coventry Integrated Network ("Network"). All medical care must be provided through the authorized Primary Care Physician in order to ensure workers Compensation benefits. (A Medical Care Coordinator will be assigned by the Claim Adjuster after the employee's injury has been diagnosed.)

**4. COMPLETE AN EMPLOYEE INTRODUCTION LETTER**

Fill in a copy of the Request For Medical Treatment Form with the appropriate information. Give the completed Request for Medical Treatment Form to the injured employee and advise him/her to give the letter to the provider he/she has chosen as his/her PCP before treatment is initiated.

**5. ARRANGE FOR THE EMPLOYEE TO BE TREATED BY A PROVIDER WITHIN THE NETWORK**

Either you, the Medical Case Manager or the Claim Adjuster should contact the PCP to confirm authorization of an appointment for treatment of the injured employee.

**6. FOLLOW-UP AND RETURN-TO-WORK**

Obtain the DWC25 form (completed by the physician) from either the injured employee or the physician's office. Work with the assigned Claim Adjuster/Medical Case Manager and the PCP to return the employee to either light or full duty. Evaluate any restrictions and offer modified duty if applicable.

## Florida Workers Compensation Managed Care Arrangement

**THE WORKERS COMPENSATION MANAGED CARE ARRANGEMENT  
REQUEST FOR MEDICAL TREATMENT FORM**

**Part 1: (To be completed by Supervisor. Please Print.)**

Employee Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date: \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Supervisor Phone Number: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Place of Injury: \_\_\_\_\_

Injury Description: \_\_\_\_\_

**Part 2: (To be completed by Employee. Employee should take this form to the Primary Care Physician or treating physician.)**

English: I authorize payment directly to the provider for the medical services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designee for medical review.

Spanish: Autorizo a que se efectúe el pago directamente al proveedor por los servicios médicos prestados, y autorizo la divulgación de información médica a la Compañía de Seguros / Administrador de Reclamaciones o a la persona designada para la revisión médica.

Creole: Mwen bay otorizasyon pou fè peman dirèk bay moun ki fè sèvis medikal pou mwen, epi mwen bay otorizasyon pou yo bay Administratè Swen Sante a/ Responsab pou Reklamasyon an, oswa moun yo nonmen pou sa, enfòmasyon medikal sou mwen, pou yo qade dosye sante m.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date:

**\*Note\* By providing this form to the Employee, neither the Carrier/Claim Administrator nor the Employer concede compensability or eligibility of the injury described above under the applicable Workers Compensation laws.**

**Part 3: Report Work Status by completing the DWC25 (To be completed by Primary Care Physician or treating physician. Please print.)**

The physician should complete the DWC25 form, give one copy to the Employee (to return to the Employer), attach one copy to your itemized bill and medical report being sent to the Carrier/Claim Administrator, and keep third copy for your records.

You can obtain a copy of the DWC25 form by calling 1-800-842-6771 and requesting the form from the Claim Adjuster. Or, the Florida Division of Workers' Compensation provides an on line interactive process for completion of the DWC25. You can access the form through the following steps:

- Web page for DWC: [www.fldfs.com/wc/forms.html](http://www.fldfs.com/wc/forms.html)
  - Select the tab for 69L-7. The DWC 25 forms can be found on this page.



## **Florida Workers Compensation Managed Care Arrangement**

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### **Part 4: (Important information for Medical Providers)**

This Employer is covered by a Workers Compensation Managed Care Arrangement that utilizes a Network of Medical Providers. If medical care for the Employee requires referral to a specialist, the Carrier/Claim Administrator will consult the Network Directory for the name of a Network Specialist.

**Please Contact the Claim Adjuster or the Medical Case Manager at 1-800-842-6771 upon any of the following:**

- Need for authorization of diagnostic studies, DME, or specialty referrals
- Hospital and inpatient facility admission;
- Outpatient knee, back, wrist, or shoulder surgery;
- Physical therapy or chiropractic care (within the first six months of injury or newly initiated, e.g., post surgical);
- Anticipated disability greater than seven days without a reasonable RTW date established (within the first six months of injury or date of disability);
- Services, which require utilization management pursuant to state law or regulation.

### **Part 5 (Claim Information)**

1. The Florida Division of Workers' Compensation now requires completion of a DWC25 form at specific time frames, such as each date of service. Please be sure that the employer and carrier receive the completed form as promptly as possible after each appointment so that timely treatment and appropriate RTW can be facilitated. For more information about the form, please contact the Claim Adjuster using 1-800-842-6771 or the DWC web page provided earlier.
2. Print the Employee's social security number and date of injury on any bills and reports. Bill only for services directly related to the work injury and submit an itemized bill and medical report, along with the completed DWC25, to the claim office.
3. Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers Compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both, imposed pursuant to applicable statutes and/or regulations.

## Florida Workers Compensation Managed Care Arrangement

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Dear Employee:

For compensable workers compensation claims, your employer provides medical care through its Workers Compensation Managed Care Arrangement ("WC/MCA").

Although everyone is committed to promoting a safe and healthy work environment, work-related illnesses and accidents can occur. In order to provide you with the best possible medical care, should a work-related illness or accident occur, your employer has implemented the Workers Compensation Managed Care Arrangement. This Arrangement includes an independent network of preferred providers available through the Coventry Integrated Network ("Network").

The Network offers many benefits including the following:

- Primary Care Physicians and medical specialty physicians
- Network Providers are credentialed to stringent standards and criteria
- Providers within the Network are experienced in treating work-related injuries and want to aid in your return-to-work when medically appropriate.

Except in emergency situations and other specific circumstances, you must obtain medical care from a Primary Care Physician within the Network in order to receive full workers compensation benefits. Your employer is prepared to assist you in accessing/selecting a Primary Care Physician who is part of the Network.

The WC/MCA promotes a team approach to treating workers compensation injuries. The team includes you, your employer, your Primary Care Physician (PCP) and/or Medical Care Coordinator (MCC), your Claim Adjuster and your Medical Case Manager. This approach provides timely, appropriate and efficient medical treatment for you and a timely return-to-work. Everyone benefits from this partnership.

Since we anticipate that you may have some questions regarding the Workers Compensation Managed Care Arrangement, we have prepared the attached reference materials.



Estimado Empleado:

Para las reclamaciones de compensación legal por accidentes de trabajo que sean compensables, su empleador proporciona cuidados médicos a través de su Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo ("WC/MCA", por sus siglas en inglés).

A pesar de que todos estamos comprometidos a fomentar un ambiente de trabajo saludable y en el que no haya riesgos, es posible que surjan enfermedades y ocurran accidentes relacionados con el trabajo. Para proporcionarle los mejores cuidados médicos posibles, en caso de que contraiga una enfermedad o sufra un accidente relacionado con el trabajo, su empleador ha implementado el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo. Este Convenio incluye una red independiente de proveedores preferidos disponible a través de la Red Coventry Integrated (la "Red").

La Red ofrece muchos beneficios, entre los que se incluyen los siguientes:

- Médicos de cabecera (PCP) y médicos especialistas
- Los Proveedores de la Red cuentan con acreditaciones obtenidas conforme a estrictas normas y criterios
- Los proveedores de la Red tienen experiencia en el tratamiento de lesiones relacionadas con el trabajo y desean prestarle ayuda para que se reincorpore al trabajo cuando sea apropiado desde el punto de vista médico.

Excepto en situaciones de emergencia y en otras circunstancias específicas, usted debe recibir cuidados médicos provenientes de un Médico de cabecera (PCP) de la Red para obtener la totalidad de los beneficios de compensación legal por accidentes de trabajo. Su empleador está preparado para ayudarle a acceder/seleccionar un médico de cabecera que pertenezca a la Red.

El convenio WC/MCA promueve un enfoque en equipo para el tratamiento de las lesiones cubiertas por la compensación legal por accidentes de trabajo. En el equipo están incluidos usted, su empleador, su médico de cabecera (PCP) y/o el Coordinador de Cuidados Médicos (MCC), su Tasador de Reclamaciones y su Gestor de Casos Médicos. Este enfoque le proporciona un tratamiento médico oportuno, adecuado y eficaz para que pueda regresar al trabajo oportunamente. Todos se benefician de esta asociación.

Como prevemos que puede tener algunas preguntas relacionadas con el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo, hemos preparado los materiales de referencia que se adjuntan.

## Florida Workers Compensation Managed Care Arrangement

### Questions & Answers

#### The Workers Compensation Managed Care Arrangement

1. Goal of Managed Care Arrangement	<p>A. Ensure provision of prompt, high quality medical care with Network physicians following a work related injury</p> <p>B. Facilitate returning to work as soon as medically possible.</p>		
2. What is a Managed Care Arrangement?	<p>A plan approved by the State of Florida for providing timely medical care through a partnership of the following participants:</p>	<p><b>Participant</b></p> <p>Network physicians</p> <p>Employers</p> <p>Carrier Claims Adjuster and Medical Case Manager</p> <p>Injured Employee</p>	<p><b>Role in Your Claim</b></p> <ul style="list-style-type: none"> <li>• Diagnose and Treat your work related injuries and make referrals to network specialty care as needed</li> <li>• Coordinate return to work with your employer</li> </ul> <ul style="list-style-type: none"> <li>• Develop transitional duty program</li> <li>• Ensure timely treatment following an injury</li> <li>• Facilitate return to work as soon as medically feasible</li> </ul> <ul style="list-style-type: none"> <li>• Contact you to discuss your accident and injury</li> <li>• Ensure you receive necessary treatment</li> <li>• Coordinate referrals and initial appointments with network providers</li> <li>• Answer questions about the WCMCA</li> <li>• Work with you, your employer and provider to facilitate return to work</li> </ul> <ul style="list-style-type: none"> <li>• Report injury as promptly as possible</li> <li>• Participate in treatment as ordered by authorized physician</li> <li>• Keep employer informed about work status and restrictions</li> <li>• Return to Work when recommended by physician and accommodated by employer</li> <li>• Discuss any problems or concerns with carrier</li> </ul>
3. Is use of WC/MCA mandatory?	<p>Yes. Only treatment provided by authorized network physicians will be compensable. Failure to follow treatment recommendations from authorized physicians may impact your claim benefits.</p>		
4. What if I need emergency treatment after an accident?	<p>You will treat at the nearest hospital or appropriate facility. Treatment will be authorized and bills will be paid. When you no longer require emergency treatment, you will be sent to a Network Primary Care Physician (PCP) for continued care.</p>		
5. Where do I go if I do not need emergency treatment?	<p>Your employer will either direct you to a physician/clinic for initial medical care, or will provide you with a list of physicians/clinics from whom you may choose your initial treating Network physician. <b>All compensable treatment must be with a Network physician authorized by your employer or the carrier before treatment begins.</b> Many network Primary Care Physicians are conveniently located 15-30 miles from your work-site, and many specialists are 30-60 miles from your work-site.</p>		
6. What do I do when I am working for my employer outside my area and need to see a doctor?	<ul style="list-style-type: none"> <li>• If the injury is <b>not an emergency</b>, contact your employer for directions. You will be provided with a local treatment center in that area and will be referred to a physician in Network when you return to your service area, if further treatment is needed.</li> <li>• If it is an <b>emergency</b> situation, seek immediate medical attention at the nearest hospital or facility.</li> </ul>		

## Florida Workers Compensation Managed Care Arrangement

7. How can I find network physicians in my area?	The names, addresses and phone numbers of Primary Care Physicians have been posted by your employer. If you do not know where the list has been posted, ask your employer for the location. If you have access to the Internet, selecting "Locate Network Medical Providers" on the <a href="http://www.mywcinfo.com">www.mywcinfo.com</a> webpage will also take you to the list of network providers.
8. What is a Primary Care Physician (PCP) and what does the PCP do?	The Primary Care Physician is a network physician licensed as a family practitioner, general practitioner, occupational medicine, occupational/urgent clinic, internist or osteopath (or other physician which your Medical Case Manager or Claim Adjuster agrees is appropriate to treat your injury). The Primary Care Physician is responsible for providing evaluation and treatment of your work related injury.
9. What is a Medical Care Coordinator (MCC) and what does the MCC do?	The Medical Care Coordinator (MCC) is a licensed network physician who serves as the "gate keeper" for medical issues related to your work injury. The MCC will help make final medical decisions in your workers compensation claim. You will probably be examined at least one time to evaluate your work injury, treatment needs and return to work needs. The MCC may or may not be your treating physician. Once assigned to your claim, the MCC probably will not change during the length of your claim. If you have specific concerns about your medical care, you can discuss them directly with the MCC.
10. What if the PCP decides I need to see a specialist (such as an orthopedist)?	If you would like to see a specialist, gain a referral from the authorized physician in your claim. All specialty referrals must be made by network physicians already authorized to provide you with treatment. Following receipt of a referral, the Claims Adjuster or Medical Case Manager will direct you to an orthopedic surgeon or other specialist within the Network. <b>Before the first appointment with a new physician, authorization must be gained from the Claims Adjuster or Medical Case Manager.</b>
11. What if I am not happy with my physician or the treatment plan for my work injury?	Contact the Medical Case Manager and/or Claim Adjuster to discuss your options. <ul style="list-style-type: none"> <li>• Florida Workers Compensation law allows for one change in provider during the life of your claim. <b>All changes must be made to network physicians in the same specialty and you cannot change physicians without prior authorization.</b> Your Medical Case Manager or Claims Adjuster will make the necessary arrangements for any change in network physician. You may be able to select a new network physician from a list provided by the Claims Adjuster only if authorization of the new physician is not provided within 5 days of receipt of your written request for the one time change in physician.</li> <li>• A second opinion may be possible if there is a referral from an authorized physician with documentation that supports the medical necessity of the need for further evaluation.</li> </ul>
12. After changing an authorized treating physician, what should I do if I am still dissatisfied?	You should immediately contact your Claim Adjuster or Medical Case Manager and express your concerns and/or dissatisfaction. If you still wish to change your Primary Care Physician or specialist, you must follow the formal grievance process (please refer to the document entitled "Grievance Procedure" attached to this document).
13. What is an Independent Medical Examination (IME)?	Once, during the life of your workers compensation claim, if there is a major disagreement with the medical recommendations from an authorized treating network physician, the injured employee and the carrier/claim administrator each have the right to gain another medical opinion through an Independent Medical Examination (IME). The carrier/claim administrator will pay for the employee's IME only when a network physician is selected for the opinion, or a decision is made to authorize the treatment recommended in the IME report. An IME physician cannot become a treating physician.
14. Who do I contact to file a grievance?	Contact the Grievance Coordinator by phone using 1-800-842-6771 or 800-448-0798 Address: Travelers Workers Compensation Managed Care Arrangement, Attention: Grievance Coordinator P. O. Box 715 Orlando, FL 32802 (Please see the "Grievance Procedure" and Grievance form attached to this document)

**Preguntas y Respuestas**

**El Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo (WC MCA)**

1. Objetivos del Convenio de Cuidados Médicos Administrados	<p>A. Garantizar la prestación de cuidados médicos oportunos y de alta calidad con médicos de la Red después de sufrir una lesión relacionada con el trabajo</p> <p>B. Facilitar la reincorporación al trabajo tan pronto como sea posible, desde el punto de vista médico.</p>		
2. ¿Qué es un Convenio de Cuidados Médicos Administrados?	Un plan aprobado por el Estado de Florida que proporciona cuidados médicos oportunos a través de una asociación de los siguientes participantes:	<p><b>Participante</b></p> <p>Médicos de la Red</p> <p>Empleadores</p> <p>Tasador de Reclamaciones de la Compañía de Seguros y Gestor de Casos Médicos</p> <p>Empleado Lesionado</p>	<p><b>Función que desempeña en lo que respecta a su reclamación</b></p> <ul style="list-style-type: none"> <li>• Diagnóstican y proporcionan tratamiento para sus lesiones relacionadas con el trabajo y están a cargo de los referidos a especialistas de la red, según sea necesario</li> <li>• Coordinan su reincorporación al trabajo junto a su empleador</li> </ul> <ul style="list-style-type: none"> <li>• Desarrollan un programa de tareas transitorias</li> <li>• Garantizan el tratamiento oportuno después de sufrir una lesión</li> <li>• Facilitan la reincorporación al trabajo tan pronto como sea posible desde el punto de vista médico</li> </ul> <ul style="list-style-type: none"> <li>• Se comunican con usted para hablar sobre su accidente y la lesión sufrida</li> <li>• Se aseguran de que reciba el tratamiento necesario</li> <li>• Coordinan los referidos y las citas iniciales con los proveedores de la red</li> <li>• Responden preguntas sobre el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo</li> <li>• Trabajan junto a usted, su empleador y su proveedor para facilitar la reincorporación al trabajo</li> </ul> <ul style="list-style-type: none"> <li>• Informa acerca de la lesión lo antes posible</li> <li>• Participa en el tratamiento de la manera indicada por el médico autorizado</li> <li>• Mantiene informado al empleador sobre su condición de trabajo y restricciones relacionadas</li> <li>• Se reincorpora al trabajo cuando así lo indica el médico y según las adaptaciones hechas por el empleador</li> <li>• Habla sobre cualquier tipo de problema o inquietud con la compañía de seguros</li> </ul>
3. ¿El uso del WC/MCA es obligatorio?	Sí. Sólo el tratamiento proporcionado por médicos autorizados de la red será compensable. El hecho de no seguir las indicaciones del tratamiento proporcionadas por un médico autorizado puede tener un impacto en los beneficios correspondientes a su reclamación.		
4. ¿Qué sucede si necesito un tratamiento de emergencia después de sufrir un accidente?	Será tratado en el hospital más cercano o en la instalación apropiada. Se autorizará el tratamiento y se pagarán las facturas. Cuando ya no necesite recibir un tratamiento de emergencia, será enviado a un Médico de Cabecera de la Red (PCP) quien se hará cargo de proporcionar los cuidados médicos posteriores.		

**Florida Workers Compensation Managed Care Arrangement**

5. ¿Dónde debo ir si no necesito un tratamiento de emergencia?	<p>Su empleador le indicará un médico/clínica a cargo de proporcionarle los cuidados médicos iniciales, o le dará una lista de médicos/clínicas para que usted elija un médico de la red que se hará cargo del tratamiento inicial. <b>Todo tratamiento compensable debe ser proporcionado por un médico de la Red autorizado por su empleador o por la compañía de seguros antes de que se dé inicio al tratamiento.</b> Muchos de los médicos de cabecera de la red se encuentran convenientemente ubicados a una distancia de 15 a 30 millas de su lugar de trabajo, y muchos especialistas a una distancia de 30 a 60 millas de su lugar de trabajo.</p>
6. ¿Qué hago si estoy trabajando para mi empleador fuera de mi área y necesito ver a un médico?	<ul style="list-style-type: none"> <li>• Si la lesión <b>no es una emergencia</b>, comuníquese con su empleador para que le dé instrucciones. Se le proporcionará un centro de tratamiento local en esa área y será referido a un médico de la Red cuando regrese a su área de servicio, si necesita recibir más tratamiento.</li> <li>• Si se trata de una situación de <b>emergencia</b>, busque atención médica de inmediato en el hospital o la instalación más cercanos.</li> </ul>
7. ¿Cómo puedo buscar médicos de la red en mi área?	<p>Los nombres, direcciones y números de teléfono de los Médicos de Cabecera han sido colocados por su empleador en un lugar visible. Si no conoce el lugar donde se encuentra la lista, pregúnteselo a su empleador. Si tiene acceso a Internet, seleccione "Locate Network Medical Providers" [Buscar Proveedores de Servicios Médicos de la Red] en la página web <a href="http://www.mywcinfo.com">www.mywcinfo.com</a> y accederá a la lista de proveedores de la red.</p>
8. ¿Qué es un Médico de Cabecera (PCP) y qué hace un PCP?	<p>El Médico de Cabecera es un médico de la red con licencia para ejercer como médico de familia, médico general, especialista en medicina ocupacional, clínica de medicina ocupacional/de atención de urgencia, especialista en medicina interna u osteópata (u otro médico que su Gestor de Casos Médicos o Tasador de Reclamaciones considere adecuado para el tratamiento de su lesión). El Médico de Cabecera es responsable de hacer la evaluación y proporcionar el tratamiento de su lesión relacionada con el trabajo.</p>
9. ¿Qué es un Coordinador de Cuidados Médicos (MCC) y qué hace un MCC?	<p>El Coordinador de Cuidados Médicos (MCC) es un médico de la red con licencia para ejercer que sirve como coordinador de los problemas de carácter médico asociados a su lesión relacionada con el trabajo. El MCC ayudará a tomar las decisiones médicas definitivas correspondientes a su reclamación de Compensación Legal por Accidentes de Trabajo. Probablemente será examinado al menos una vez para evaluar su lesión relacionada con el trabajo, las necesidades en cuanto a tratamiento y las necesidades en cuanto a su reincorporación al trabajo. El MCC puede o no ser el médico a cargo de su tratamiento. Una vez que haya sido asignado a su reclamación, el MCC probablemente seguirá siendo el mismo durante el tiempo que dure su reclamación. Si tiene inquietudes específicas en cuanto a sus cuidados médicos, puede hablar directamente con el MCC.</p>
10. ¿Qué sucede si el PCP decide que es necesario que yo consulte a un especialista (por ejemplo, a un ortopedista)?	<p>Si usted desea consultar a un especialista, obtenga un referido del médico autorizado de su reclamación. Todos los referidos para ser atendido por especialistas deben ser hechos por médicos de la red que ya tienen autorización para proporcionarle tratamiento. Despues de obtener un referido, el Tasador de Reclamaciones o el Gestor de Casos Médicos le derivarán a un cirujano ortopedista o a otro especialista de la red. <b>Antes de la primera cita con un nuevo médico, debe obtener una autorización del Tasador de Reclamaciones o del Gestor de Casos Médicos.</b></p>
11. ¿Qué sucede si no estoy satisfecho con mi médico o con el plan de tratamiento para mi lesión relacionada con el trabajo?	<p>Comuníquese con el Gestor de Casos Médicos y/o con el Tasador de Reclamaciones para hablar sobre sus opciones.</p> <ul style="list-style-type: none"> <li>• La ley de Compensación Legal por Accidentes de Trabajo de Florida permite un cambio de proveedor durante la vigencia de su reclamación. <b>Todos los cambios deben hacerse a médicos de la red de la misma especialidad y usted no puede cambiar de médico si no cuenta con la autorización previa.</b> Su Gestor de Casos Médicos o Tasador de Reclamaciones hará los arreglos necesarios para efectuar cualquier tipo de cambio a un médico de la red. Usted podrá seleccionar un nuevo médico de la red de una lista proporcionada por el Tasador de Reclamaciones sólo si la autorización para el nuevo médico no es proporcionada dentro de los 5 días posteriores a la recepción de su solicitud por escrito para realizar el cambio del médico de la red por única vez.</li> </ul>

**Florida Workers Compensation Managed Care Arrangement**

	<ul style="list-style-type: none"> <li>• Es posible solicitar una segunda opinión si existe un referido proporcionado por un médico autorizado con documentación que respalde la necesidad médica de que se realicen más exámenes.</li> </ul>
12. Despues de cambiar de médico autorizado, ¿qué debo hacer si aún no estoy satisfecho?	Deberá comunicarse de inmediato con su Tasador de Reclamaciones o Gestor de Casos Médicos y expresar sus inquietudes y/o insatisfacción. Si aún desea cambiar de médico de cabecera o médico especialista, debe seguir el proceso de presentación de quejas formales (consulte el documento titulado "Procedimiento de Presentación de Quejas Formales" que se adjunta a este documento).
13. ¿Qué es un Examen Médico Independiente (IME)?	Por única vez, durante la vigencia de su reclamación de Compensación Legal por Accidentes de Trabajo, si existe un desacuerdo importante en lo que respecta a las indicaciones médicas proporcionadas por un médico de la red a cargo del tratamiento, el empleado lesionado y la compañía de seguros/gestor de reclamaciones tienen individualmente el derecho de obtener otra opinión médica a través de un Examen Médico Independiente (IME). La compañía de seguros/el gestor de reclamaciones pagará la IME del empleado sólo cuando se seleccione a un médico de la red para dar la opinión, o bien se tome una decisión para autorizar el tratamiento recomendado en el informe de la IME. El médico a cargo de la IME no puede convertirse en el médico a cargo del tratamiento.
14. ¿Con quién me comunico para presentar una queja formal?	<p>Comuníquese con el Coordinador de Quejas Formales por teléfono llamando al 1-800-842-6771, o al 800-448-0798.</p> <p>Dirección: Travelers Workers Compensation Managed Care Arrangement  Attention: Grievance Coordinator  P. O. Box 715  Orlando, FL 32802</p> <p>(Lea el "Procedimiento de Presentación de Quejas Formales" y el formulario de Presentación de Queja Formal que se adjuntan a este documento)</p>



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## Florida Workers Compensation Managed Care Arrangement

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### THE TRAVELERS WORKERS COMPENSATION MANAGED CARE ARRANGEMENT NETWORK SERVICES

#### Employee Satisfaction Survey

Our goal is for you to be satisfied with the medical treatment provided during participation in the Travelers Workers Compensation Managed Care Program. We are concerned about the quality of services received from network providers. The form on the following page is a feedback mechanism for expressing the results of medical treatment, both good and bad.

This feedback form is used by Travelers when a specific quality concern has been identified and/or in a random survey process to determine satisfaction with the providers in the workers compensation network.

#### For the Employee:

If you have been particularly pleased or frustrated by the treatment you received, we will forward a copy of your completed survey to our Managed Care Network, Coventry Integrated Network. Coventry will address the provider concerns you have expressed in your survey. If they have additional questions, a representative from Coventry may contact you directly.

#### For the Employer: You may want to use this form when an employee expresses:

- Exceptional satisfaction with care that was provided
- Dissatisfaction with care that was provided
- Concerns about the facility/office
- Positive experiences with the facility/office

When an employee is dissatisfied please encourage them to provide their address on the survey in case it is necessary to make contact for additional information.

Florida Workers Compensation Managed Care Arrangement

THE TRAVELERS WORKERS COMPENSATION  
MANAGED CARE ARRANGEMENT INDEPENDENT NETWORK SERVICES

We want you to be satisfied with the medical treatment you have received as a participant in the Travelers Workers Compensation Managed Care Program. We appreciate your input on the following:

(Name of Provider/Clinic)

(Please circle appropriate choice)

1. Was the clinic or office clean?
  - A. very clean
  - B. somewhat clean
  - C. dirty
  - D. very dirty
2. How long did you wait to be seen by the medical staff?
  - A. less than 20 min.
  - B. 30-45 min.
  - C. 45 min- 1 1/2 hrs.
  - D. over 1 1/2 hrs.
3. Were you treated with care and attention?
  - A. very much so
  - B. careful and attentive
  - C. not so careful or attentive
  - D. very inattentive
4. Did the medical staff explain your diagnosis and/or treatment plan?
  - A. very much so
  - B. explained somewhat
  - C. did not fully cover all issues
  - D. did not explain at all
5. Overall, were you satisfied with your visit?
  - A. very satisfied
  - B. somewhat satisfied
  - C. somewhat dissatisfied
  - D. very dissatisfied

ADDITIONAL COMMENTS: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

\*\*\*\*\*Please return this completed questionnaire to:

The Workers Compensation Managed Care Arrangement  
Travelers  
P.O. Box 715, Orlando, Florida 32802

**SERVICIOS DE LA RED DEL CONVENIO DE CUIDADOS MÉDICOS  
ADMINISTRADOS DE COMPENSACIÓN LEGAL POR ACCIDENTES DE  
TRABAJO DE TRAVELERS**

**Encuesta de Satisfacción del Empleado**

Nuestro objetivo es que usted esté satisfecho con el tratamiento médico proporcionado durante la participación en el Programa de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo de Travelers. Nos preocupamos por los servicios que ha recibido de los proveedores de la red. El formulario de la página siguiente es un mecanismo para brindar comentarios y sugerencias que permite expresar los resultados del tratamiento médico, tanto positivos como negativos.

Este formulario de comentarios y sugerencias es utilizado por Travelers cuando se ha identificado alguna inquietud específica en lo que respecta a la calidad y/o en un proceso aleatorio de encuestas para determinar la satisfacción con los proveedores de la Red de Compensación Legal por Accidentes de Trabajo.

**Para el Empleado:**

Si se ha sentido particularmente satisfecho o frustrado por el tratamiento que recibió, le enviaremos una copia de la encuesta que ha llenado a nuestra Red de Cuidados Médicos Administrados, Coventry Integrated Network. Coventry abordará las inquietudes en cuanto a los proveedores que usted ha incluido en su encuesta. Si tiene más preguntas, un representante de Coventry puede comunicarse directamente con usted.

**Para el Empleador:** Puede utilizar este formulario cuando un empleado exprese:

- Una satisfacción excepcional en lo que respecta a los cuidados proporcionados
- Insatisfacción en lo que respecta a los cuidados proporcionados
- Inquietudes sobre la instalación/oficina
- Experiencias positivas en relación con la instalación/consultorio

Cuando un empleado no esté satisfecho, invítelo a incluir su dirección en la encuesta por si es necesario comunicarse con él para obtener más información.

Florida Workers Compensation Managed Care Arrangement

**SERVICIOS DE RED INDEPENDIENTE  
DE CONVENIO DE ATENCIÓN MÉDICA DIRIGIDA  
DE COMPENSACIÓN LABORAL DE THE TRAVELERS**

Deseamos que usted se sienta satisfecho con el tratamiento médico que ha recibido como participante del Programa de Atención Médica Dirigida de Compensación Laboral de Travelers. Agradeceríamos su información sobre lo siguiente:

(Nombre del Proveedor o Clínica)

(Favor circular la selección adecuada)

1. ¿Estaba limpia la clínica o consulta?
  - A. muy limpia
  - B. más o menos limpia
  - C. sucia
  - D. muy sucia
2. ¿Cuánto tuvo que esperar para que lo vieran los médicos?
  - A. menos de 20 min.
  - B. 30-45 min.
  - C. 45 min- 1 ½ horas
  - D. más de 1 ½ horas
3. ¿Lo trataron con cuidado y atención?
  - A. con mucho cuidado y mucha atención
  - B. con cuidado y atención
  - C. sin tanto cuidado ni atención
  - D. muy desatentamente
4. ¿Le explicaron los médicos su diagnóstico y/o el plan de tratamiento?
  - A. explicaron en detalle
  - B. explicaron en cierta medida
  - C. no cubrieron todas las cuestiones
  - D. no explicaron nada
5. En general, ¿quedó satisfecho con su visita?
  - A. muy satisfecho
  - B. satisfecho en parte
  - C. insatisfecho en parte
  - D. muy insatisfecho

COMENTARIOS ADICIONALES: \_\_\_\_\_

NOMBRE: \_\_\_\_\_ FECHA: \_\_\_\_\_

DIRECCIÓN: \_\_\_\_\_ TELÉFONO: \_\_\_\_\_

\*\*\*\*\*Devuelva este cuestionario debidamente llenado a:

The Workers Compensation Managed Care Arrangement  
Travelers  
P. O. Box 715  
Orlando, Florida 32802

**THE WORKERS COMPENSATION MANAGED CARE ARRANGEMENT  
EMPLOYEE RIGHTS & RESPONSIBILITIES**

Your Employer and workers compensation Carrier/Claim Administrator are committed to seeing that you receive appropriate medical treatment if you are injured on the job. Because you are a significant partner in your recovery, it is important that you understand your Workers Compensation Managed Care rights and responsibilities.

**Employee Rights**

- Prompt emergency treatment when needed (preferably through network facilities)
- Timely coordination of medical care ordered by authorized network physicians
- Return to Work as soon as medically feasible (possibly to modified duty, initially)
- Assistance in selection of Primary Care Physician
- Use of Grievance Policy (attached) to resolve disagreements about medical care
- Discussion of medical and Return to Work plans with the Medical Care Coordinator (MCC – gatekeeper) including:
  - ¾ Referral to a network physician or specialist
  - ¾ One time change in network physician during life of your claim
  - ¾ Possible second opinion with network provider
- Use of one Independent Medical Examination (IME), to gain another opinion about medical care
- Once during the life of the claim, a change in authorized physician, to another Network physician in the same specialty
- Medical treatment within reasonable distance from your usual work site (i.e., primary care within 30 miles and specialty care within 60 miles.)
- Medical care with a non-Network physician only if:
  - ¾ Physician is providing emergency care
  - ¾ Compensability of the claim has been denied
  - ¾ Physician provides medically necessary service that is not available through the Network and the service has been ordered by an authorized treating Network physician
- You should not receive billing from any authorized provider treating your work related injury. If you receive billing, contact your Claims Adjuster.
- For additional information about rights and responsibilities, contact the State of Florida's Workers' Compensation Employee Assistance Office using 800-342-1741

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both.

If you have any questions, you may contact the WORKERS COMPENSATION MANAGED CARE ARRANGEMENT using: **1-800-842-6771** or your employer.

**Employee Responsibilities**

- Report your injury to your employer as promptly as possible
- If you are not clear about your rights and responsibilities, ask your employer and/or Travelers for assistance
- Participate in medical care with Network providers identified by or selected by your employer and/or Travelers.
- Participate in medical care as ordered by the authorized treating Network physician. If you are not working, participating in medical treatment is your job until you are able to Return to Work.
- For each medical appointment be sure to gain documentation of your Return to Work status and restrictions and give the document to your employer.
- Return to Work when released by your authorized treating Network physician and work within the restrictions (if any) identified by the physician.
- If you would like new or different medical care, discuss your request with the Medical Care Coordinator (MCC – gatekeeper) and/or treating Network physician
- If you have a complaint about your care, contact the Claims Adjuster or Medical Case Manager so that they can help resolve the problem.
- If the problem continues, by Florida law you must utilize the Grievance procedures to attempt to resolve the problem before filing a Petition for Benefits.

*\* Failure to cooperate with medical treatment may negatively affect (reduce or eliminate) your claim benefits.*

**EL CONVENIO DE CUIDADOS MÉDICOS ADMINISTRADOS DE COMPENSACIÓN LEGAL POR  
ACCIDENTES DE TRABAJO**

**DERECHOS Y RESPONSABILIDADES DEL EMPLEADO**

Su empleador y el gestor de reclamaciones/compañía de seguros de compensación legal por accidentes de trabajo tienen el compromiso de verificar que usted reciba el tratamiento médico adecuado si sufre una lesión en el trabajo. Debido a que usted es una parte significativa en lo que respecta a su recuperación, es importante que entienda los derechos y las responsabilidades relacionados a los Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo.

**Derechos del empleado**

- Tratamiento de emergencia de inmediato cuando sea necesario (preferentemente a través de las instalaciones de la red).
- Coordinación oportuna de los cuidados médicos indicados por los médicos autorizados de la red.
- Reincorporación al trabajo tan pronto como sea posible, desde el punto de vista médico (posiblemente a tareas modificadas, en un comienzo).
- Ayuda para la selección de un Médico de Cabeza (PCP).
- Uso de la Política de Presentación de Quejas Formales (adjunta) para resolver desacuerdos en lo que respecta a los cuidados médicos.
- Conversación acerca de los planes médicos y de reincorporación al trabajo con el Coordinador de Cuidados Médicos (MCC – coordinador) incluyendo:
  - ¾ Referidos a un médico o especialista de la red
  - ¾ Cambio por única vez de médico de la red durante la vigencia de su reclamación
  - ¾ Segunda opinión posible a cargo de un médico de la red
- Uso de un Examen Médico Independiente (IME) para obtener otra opinión sobre los cuidados médicos.
- Por única vez durante la vigencia de la reclamación, un cambio de médico autorizado a otro médico de la red, de la misma especialidad.
- Tratamiento médico a una distancia razonable de su trabajo habitual (por ejemplo, servicios de atención primaria dentro de las 30 millas, y servicios de atención especializada dentro de las 60 millas).
- Cuidados médicos proporcionados por un médico que no pertenezca a la red, sólo si:
  - ¾ El médico proporciona cuidados de emergencia
  - ¾ Se ha denegado la compensación de la reclamación
  - ¾ El médico proporciona un servicio médico clínicamente necesario que no está disponible a través de la red y el servicio ha sido solicitado por un médico de la red a cargo del tratamiento
- Usted no recibirá facturas de ningún proveedor autorizado que esté a cargo del tratamiento de su lesión relacionada con el trabajo. Si recibe facturas, comuníquese con el Tasador de Reclamaciones.

**Responsabilidades del empleado**

- Para obtener información adicional sobre derechos y responsabilidades, comuníquese con la Oficina de Asistencia al Empleado de Compensación Legal por Accidentes de Trabajo del Estado de Florida llamando al 800-342-1741.
- Informe sobre su lesión a su empleador lo antes posible.
- Si no está seguro de sus derechos y responsabilidades, solicite ayuda a su empleador y/o a Travelers.
- Reciba cuidados médicos de proveedores de la red identificados o seleccionados por su empleador y/o Travelers.
- Reciba cuidados médicos según lo indicado por el médico autorizado de la red a cargo del tratamiento. Si no está trabajando, su tarea es participar en el tratamiento médico hasta que pueda volver a trabajar.
- En cada cita con el médico, asegúrese de obtener la documentación sobre su condición para la reincorporación al trabajo así como las restricciones, y entregue ese documento a su empleador.
- Reincorpórese al trabajo cuando el médico autorizado de la red a cargo de su tratamiento le autorice a hacerlo, dentro de las restricciones (si las hubiera) identificadas por el médico.
- Si desea recibir cuidados médicos nuevos o diferentes, hable sobre su solicitud con el Coordinador de Cuidados Médicos (MCC – coordinador) y/o con el médico de la red a cargo de su tratamiento.
- Si tiene una queja formal sobre los cuidados médicos recibidos, comuníquese con el Tasador de Reclamaciones o con el Gestor de Casos Médicos para que le ayuden a resolver el problema.
- Si el problema continúa, conforme a las leyes de Florida usted debe usar los Procedimientos de Presentación de Quejas Formales para intentar resolver el problema antes de presentar una Solicitud de Beneficios.

*\* El hecho de no colaborar con el tratamiento médico puede afectar de manera negativa (reducir o eliminar) los beneficios correspondiente a su reclamación.*

## Florida Workers Compensation Managed Care Arrangement

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Cualquier persona o entidad que voluntaria y deliberadamente haga cualquier declaración o manifestación importante falsa con el fin de obtener algún beneficio o pago, o con el propósito de frustrar o, de manera indebida, incrementar o reducir cualquier reclamación para beneficio o pago de cobertura de la compensación legal por accidentes de trabajo, o que contribuya o incite a tal finalidad, podrá quedar sujeta a sanciones civiles o penales, o a ambas.

Si tiene alguna pregunta, puede comunicarse con el CONVENIO DE CUIDADOS MÉDICOS ADMINISTRADOS DE COMPENSACIÓN LEGAL POR ACCIDENTES DE TRABAJO llamando al: **1-800-842-6771** o a su empleador.

### GRIEVANCE POLICY

Your employer and the WC/MCA want to ensure that you receive appropriate medical treatment in the event you are injured on the job. If you would like treatment with a specialist or other medical services, you may contact your MCC or authorized treating physician to gain a referral. The grievance policy only applies to medical requests from authorized treating physicians in a specific claim.

1. Your first request for authorization of a physician or a medical service should always be made to the Case Manager or Adjuster who will strive to resolve your issue as promptly as possible. Your request may be referred to the MCC assigned to your claim, or an independent Physician Advisor. An opinion will be provided concerning the medical necessity and/or appropriateness of the request as related to your injury. You will receive a response to your concern within 7-14 days after we receive your request.
2. If at any time you are dissatisfied or have a complaint concerning the medical care and treatment provided for your work related injury, you should contact your Case Manager or Adjuster. Every effort will be made to resolve your complaint within 10 days of receipt. With your agreement, additional time may be utilized (if necessary) to resolve the problem.
3. If a specific request has been denied, within one year from the date of denial, you may file a formal written Grievance with the Grievance Coordinator of the WC/MCA. The Grievance Coordinator will review your case and make administrative decisions concerning your request. A decision will be provided within 14 days from the date we receive your written Grievance Form, and you will be promptly notified in writing of the results.

Specifically when you are requesting a second change in physician (after your statutory 1 time change in physician), you must attach medical documentation to the Grievance Form which substantiates that: you have not made significant progress in recovery after 6 months of treatment; treatment is not consistent with AHRQ guidelines; and/or treatment is not consistent with established codes of ethical medical conduct. The grievance process does not begin in this case without the necessary documentation attached to the Grievance Form.

Following review of your request by the Grievance Coordinator, if the request continues to be denied, you will be informed that your request will be forwarded to the Grievance Committee for review. The committee, including a Florida licensed physician, will review the request within 30 days of the committee's receipt of the grievance. Occasionally, an additional 14 days is needed because additional information is required. You will be promptly informed in writing, of the Grievance Committee status and decision.

4. You may file an "Urgent Grievance" if your PCP or MCC determines that your medical status is at significant risk of deterioration if a response is not made within 72 hours. The Grievance Coordinator will review the request and notify you of the decision within 3 days.

**For both the formal Grievance and the Urgent Grievance requests, completion of AHCA form No. 3160-0019 is required.** According to Florida Workers Compensation law, a Petition for Benefits is not a Grievance, and the Petition for Benefits form may not be used to replace the Grievance Form. The Grievance Form is attached, or you may use the contact information below to request the form.

According to Florida law, you may file a Petition for Benefits only upon completion of the grievance process above. The Workers Compensation Employee Assistance Office can be contacted at 200 East Gaines St., Tallahassee, FL 32399-4225. You may also contact the Employee Assistance Office using 800-342-1741.

Every effort will be made to resolve your grievance at the earliest possible time. Most verbal requests or complaints can be resolved at the time of the initial telephone conversation. At any time during the processing of your grievance, you may request a personal meeting to be held at a convenient location.

If you have any questions concerning the WC MCA Grievance Process, please call 1-800-448-0798 or write:

Travelers  
Workers Compensation Managed Care Arrangement  
ATTN: GRIEVANCE COORDINATOR  
P. O. Box 715  
Orlando, FL 32802

## POLÍTICA DE PRESENTACIÓN DE QUEJAS FORMALES

Su empleador y WC MCA quieren asegurarse de que usted reciba el tratamiento médico adecuado en caso de que sufra una lesión en su trabajo. Si desea recibir tratamiento por parte de un especialista u otros servicios médicos, puede comunicarse con su MCC o con el médico autorizado a cargo de su tratamiento para que le otorguen un referido. La política de presentación de Quejas Formales sólo se aplica a solicitudes médicas de médicos autorizados a cargo del tratamiento en una reclamación específica.

1. Su primera solicitud de autorización de médico o servicio médico debe presentarse siempre al Gestor de Casos o al Tasador quienes se esforzarán por resolver su problema lo antes posible. Su solicitud puede ser referida al MCC asignado a su reclamación, o a un Asesor Médico Independiente. Se dará una opinión en lo que respecta a la necesidad médica y/o a la idoneidad de la solicitud en relación con su lesión. Recibirá una respuesta a su inquietud entre los 7 y los 14 días posteriores a la recepción por parte nuestra de la solicitud.
2. Si en algún momento no se siente satisfecho o tiene una queja relacionada con el tratamiento y los cuidados médicos proporcionados para su lesión relacionada con el trabajo, comuníquese con su Tasador o Gestor de Casos. Haremos todos los esfuerzos posibles para encontrar una solución a su queja dentro de los 10 días posteriores a la recepción de la misma. Con su consentimiento, podemos hacer uso de tiempo adicional para resolver el problema (de ser necesario).
3. Si se ha denegado una solicitud específica, dentro de un plazo de un año contado a partir de la fecha de la denegación, usted puede presentar una queja formal por escrito al Coordinador de Quejas Formales del WC MCA. El Coordinador de Quejas Formales revisará su caso y tomará las decisiones administrativas relacionadas con su solicitud. Se tomará una decisión dentro de los 14 días posteriores a la recepción por parte nuestra de su Formulario de Presentación de Queja Formal, y le proporcionaremos a la brevedad una notificación por escrito de los resultados.

Específicamente cuando usted nos solicite un segundo cambio de médico (después de solicitar el reglamentario cambio de médico por única vez), debe adjuntar la documentación médica al Formulario de Presentación de Queja Formal que pruebe que: no se han logrado avances de importancia en la recuperación después de 6 meses de tratamiento; el tratamiento no concuerda con las directrices de la Agencia de Investigación y Calidad de la Atención Médica (AHRQ, por sus siglas en inglés); y/o el tratamiento no concuerda con los códigos de ética médica establecidos. No se da inicio en este caso al proceso de presentación de quejas formales si no se adjunta la documentación necesaria al Formulario de Presentación de Queja Formal.

Después de que el Coordinador de Quejas Formales revise su solicitud, si se sigue denegando la solicitud, se le informará que su solicitud será enviada al Comité de Quejas Formales para su revisión. El comité, que incluye un médico con licencia de Florida, revisará la solicitud dentro de los 30 días posteriores a la fecha en que el comité reciba la queja formal. De vez en cuando, se necesitan 14 días más porque es necesario obtener más información. Se le informará por escrito a la brevedad acerca del estado y la decisión del Comité de Quejas Formales.

4. Puede presentar una "Queja Formal Urgente" si su PCP o MCC determina que su condición médica muestra un riesgo significativo de deterioro si no se obtiene una respuesta dentro de un plazo de 72 horas. El Coordinador de Quejas Formales revisará la solicitud y le notificará sobre la decisión en un plazo de 3 días.

**Tanto para las solicitudes de Queja Formal y Queja Formal Urgente, se requiere completar el formulario No. 3160-0019 de la Agencia para la Administración del Cuidado de la Salud (AHCA).** Conforme a la ley de Compensación Legal por Accidentes de Trabajo de Florida, una de Solicitud de Beneficios no es una Queja Formal, y el formulario de Solicitud de Beneficios no puede ser utilizado para reemplazar un Formulario de Presentación de Queja Formal. Se adjunta el Formulario de Presentación de Queja Formal, o bien, usted puede usar la información que aparece más abajo para solicitar el formulario.

Conforme a las leyes de Florida, usted puede presentar una Solicitud de Beneficios sólo después de completar el proceso de presentación de queja formal que se indica más arriba. Puede comunicarse con la Oficina de Asistencia al Empleado de Compensación Legal por Accidentes de Trabajo [Workers Compensation Employee Assistance Office] que se encuentra en 200 East Gaines St., Tallahassee, FL 32399-4225. También puede comunicarse con la Oficina de Asistencia al Empleado llamando al 800-342-1741.

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## Florida Workers Compensation Managed Care Arrangement

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Se harán todos los esfuerzos posibles para resolver su queja formal lo antes posible. La mayoría de las solicitudes o quejas formales pueden ser resueltas en la conversación telefónica inicial. En cualquier momento, mientras se procesa su queja formal, puede solicitar una reunión personal a ser realizada en una ubicación que le resulte conveniente.

Si tiene alguna pregunta sobre el Proceso de Presentación de Quejas Formales de WC MCA, llame al 1-800-448-0798 o escriba a:

**Travelers Workers Compensation Managed Care Arrangement**  
Attn: GRIEVANCE COORDINATOR,  
P. O. Box 715, Orlando, FL 32802



## Florida Workers Compensation Managed Care Arrangement

See Reverse of Form for Information Regarding Filing a Grievance  
Florida Workers' Compensation Managed Care Arrangement

## **FORMAL GRIEVANCE FORM**

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

The Grievance is being filed by:  Provider  Injured Worker / Designated Representative  Family Member  
 Attorney  Other

Date of Injury: \_\_\_\_\_

INJURED WORKER'S /PROVIDER'S NAME: \_\_\_\_\_

Social Security Number \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work / Alternate Phone: \_\_\_\_\_

Contact if other than injured worker or provider \_\_\_\_\_ Telephone # \_\_\_\_\_

PRIMARY CARE / TREATING PHYSICIAN: \_\_\_\_\_

Address: \_\_\_\_\_

Office Telephone: \_\_\_\_\_

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem):

Has a grievance been previously filed?  YES  NO. If YES, Date Sent? \_\_\_\_\_

What Action Would You Like to See Taken? \_\_\_\_\_

Have you received any information regarding your rights and responsibilities under WC Managed Care?  
YES NO

Form 3160-0019 November, 2000

## Florida Workers Compensation Managed Care Arrangement

**INTENT:** The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt, unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

**The injured worker's participation in the grievance process is important to the resolution of medical issues.** Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

**Form Completed by:**

**Injured Worker/Provider/Other**

---

**Date Form Completed/Signed**

**Signature of Grievance Coordinator**

Date Grievance Coordinator Signed

MAIL TO:

The Workers Compensation Managed Care Arrangement  
Travelers  
ATTN: GRIEVANCE COORDINATOR  
P.O. Box 715  
Orlando, FL 32802



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**Florida Workers Compensation Managed Care Arrangement**

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**FLORIDA WORKERS COMPENSATION MANAGED CARE**

**Acknowledgement Form:**

I acknowledge receipt, review and understanding of the Florida Workers Compensation Managed Care educational materials.

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Date

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Name

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Signature

## Florida Workers Compensation Managed Care Arrangement

## ATENCIÓN ADMINISTRADA DE LA FLORIDA

### Formulario de Acuse de Recibo:

Reconozco que he recibido, revisado y entendido los materiales informativos de Atención Administrada de Compensación Legal por Accidentes de Trabajo de la Florida.

Fecha

Nombre

Firma





## FLORIDA POLICYHOLDERS AVAILABILITY OF RISK MANAGEMENT PLANS

Florida insurance statute require insurers to provide insureds, at their request, with guidelines for risk management plans. Travelers Risk Control department has available guidelines to assist you with your accident prevention activities.

The companion Safety Services notice describes the range of services available to our insureds. Should you desire assistance with regard to your accident prevention activities, please contact us at the Florida location specified in the notice.



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## FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

**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:

- |   |  |
|---|--|
| <input type="checkbox"/> Job applicant        | <input type="checkbox"/> Routine fitness for duty                          |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Programs |

**Notice of Employer's Drug Testing Policy:**

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

**Education:**

- |  |
|--|
| <input type="checkbox"/> Resource file on providers  |
| <input type="checkbox"/> Employee Assistance Program |
| <input type="checkbox"/> 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:

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B. Phone #: (        ) \_\_\_\_\_

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.

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Employer Name

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Date

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Officer/Owner Signature \*

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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.

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Notary Public's Signature

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Date

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Expiration of Commission

(NC3010)  
Form 09-1

002894 W09NDG04



# FLORIDA SAFETY SERVICES

**Notice to policy recipient:** If you are not the person directly responsible for the loss control activities for your company, please direct this Loss Control notice to the person that is directly responsible for them

## SAFETY IS OUR CONCERN

Thank you for purchasing your insurance from one of the writing companies owned or managed by The Travelers Companies, Inc. We appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns safety and accident prevention. Travelers Risk Control department has the experience, resources and capabilities to provide a range of safety services, including site surveys, phone consultations, and a wealth of safety-related materials.

We have experience in a variety of industries, some of which include manufacturing, wholesale and retail businesses, service organizations, technology-related business, oil and gas-based business, and the public sector.

Following are some examples of available loss control services:

**Accident Prevention** – Our staff can help you identify present and potential hazards in your operations, premises and equipment, and recommend measures for reducing or eliminating these hazards.

**Analysis of Accident Causes** – Although you investigate and keep records of accidents, we are available to assist if needed.

**Safety Consultations** – Our Consultants can help you with special problems such as ergonomics and human factors.

**These services are available upon request. Please call us at 407-388-3307 for loss control assistance. Please do not call this number for questions regarding your policy or claims. For all other inquiries, please contact your underwriter or agent.**

**Industrial Hygiene/Health Services** – We have the facilities and resources to answer your questions concerning job related industrial hygiene/health issues and to measure exposure to industrial hygiene hazards.

**Safety Literature and Digital Media** – We can provide you with top-notch safety-related literature, CDs, DVDs, and videos to assist in your loss control efforts. Also, we can direct you to several vendors who are able to provide additional safety materials, including brochures, pamphlets and digital media.

**Safety Training** – We offer face-to-face classroom courses, as well as distance learning programs that explore the risks our policyholders face and ways for them to control losses.

**Return-To-Work Coordination** – We can assist you with several aspects of the post injury management process.

**Internet Website** – Visit our Risk Control website for access to our safety newsletters and other safety literature at:

**<http://www.travelers.com/riskcontrol>**

This website also has links to other safety-related Internet sites.



## SAFETY IS YOUR CONCERN

U.S. employers spend billions of dollars each year on the direct and indirect costs of work-related accidents. Dollar figures can't begin to reflect the pain and suffering of an injured worker and his or her family. But they do give some indication of the multiple consequences of a job-related accident... loss of time, interrupted production, damaged materials and equipment, the expense of retraining or replacing an injured worker, possible legal action from government regulatory agencies, and increased insurance costs.

It makes good sense for both employers and their employees to actively participate in a sound accident prevention program. The success of such a program depends to a large extent on your commitment to safety procedures and accident prevention techniques. Safety is a management concern. Maybe we can help.

You may want to consider the following "Safety Checkpoints" as you evaluate your organization's safety activities:

### SELF-INSPECTION PROGRAM:

- Do you conduct periodic surveys of premises?... equipment?... operations?

### SELF-INSPECTION PROGRAM (continued):

- Do you analyze each job to find inherent hazards?
- If you discover hazards, do you follow up with immediate corrective action?
- Do you monitor such action to make sure it is implemented and effective?

### ACCIDENT INVESTIGATION:

- Do you investigate each accident?... determine the cause?
- Do you take immediate steps to prevent a recurrence?
- Do you keep records of accident investigations and follow-up measures?
- Do you complete accident statistics and analyze trends?

### EDUCATION AND TRAINING:

- Do you take the time to train each of your employees to perform tasks safely?
- Do more-experienced employees receive training to correct bad habits that have developed over time?
- Do all employees understand that safety is an important part of their jobs?

## IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

### Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Physical therapy
- Hospitalization
- Medical tests
- Prostheses
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a \$10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

### Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- **Temporary Total Benefits:** These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- **Temporary Partial Benefits:** These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. **Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.**
- **Permanent Impairment Benefits:** These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.

# **IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS**

- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

## **Injured Worker Responsibilities**

### **Communicate with the Employer:**

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

### **Communicate with the Carrier:**

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned.  
(Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

### **Communicate with the Authorized Treating Physician:**

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).

# IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

## Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

## Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at [http://www.MyFloridaCFO.com/WC/organization/eao\\_offices.html](http://www.MyFloridaCFO.com/WC/organization/eao_offices.html).

### Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at [www.MyFloridaCFO.com/WC/employee/index.html](http://www.MyFloridaCFO.com/WC/employee/index.html), and answers to frequently asked questions can be accessed at [www.MyFloridaCFO.com/WC/faq/faqwrkrs.html](http://www.MyFloridaCFO.com/WC/faq/faqwrkrs.html).

You may also submit specific questions relating to your claim to us at [wceao@MyFloridaCFO.com](mailto:wceao@MyFloridaCFO.com) and receive answers directly by e-mail.

## Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

## Denial of Benefits

## **IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS**

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is free and available by contacting the EAO at **1-800-342-1741**.

### **Petition for Benefits**

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at [www.jcc.state.fl.us/jcc/forms.asp](http://www.jcc.state.fl.us/jcc/forms.asp).

### **Re-employment Services**

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at [www.rehabworks.org](http://www.rehabworks.org) or call 850-245-3470 for free re-employment services.

### **Legal Representation**

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

### **Anti-Fraud Reward Program**

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

### **Disclaimer:**

*This publication is being offered as an informational tool only and complies with s.440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.*

# INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

Si usted se lesioná como resultado de un accidente de trabajo, la compañía de seguro de su empleador podría proveerle beneficios médicos y una porción de su salario.

## Beneficios Médicos

Tan pronto la compañía de seguro tenga conocimiento de su lesión y determine que su lesión/enfermedad tiene cobertura de acuerdo a las leyes de la Florida, la compañía de seguro le:

- Proveerá un médico autorizado por la compañía de seguro
- Pagará por todo tratamiento que sea autorizado, médicaamente necesario y relacionado a su lesión o enfermedad
- Proveerá una vez un cambio de medico dentro de cinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de viajes a consultas médicas o la farmacia

En cuanto alcance la máxima mejoría médica (MMI por su sigla en inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo(a) atiende determina que su lesión o enfermedad ha sanado hasta el punto que una mejoría adicional no es probable.

## Beneficios de Reemplazo de Salario

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su empleo, es posible que usted pueda recibir reemplazo parcial del salario. Usted puede ser elegible para estos beneficios si ha estado incapacitado(a) por mas de siete días y no ha podido cumplir con sus deberes normales en su empleo según el consejo de su médico autorizado.

Si usted califica, los beneficios de reemplazo de salario comenzarán al octavo día de incapacidad parcial o total. Usted no recibirá beneficio de reemplazo de salario por los primeros siete días de incapacidad a menos que usted ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionado con su empleo.

En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular que usted ganaba antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Usted generalmente, puede esperar recibir su primer cheque de beneficio dentro de 21 días después de que la compañía de seguro tenga conocimiento de su lesión o enfermedad. Los (siguientes) cheques (adicionales) se enviarán quincenalmente.

- Beneficios Por Incapacidad Total Temporal (TTD por su sigla en inglés)\* :Estos beneficios son proveídos como resultado de una lesión u enfermedad que temporalmente prohíbe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.

## **INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA**

- Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)\* :Estos beneficios son proveídos cuando el médico le permite volver a trabajar, usted no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad.\* **Beneficios temporales son pagables por un máximo de 104 semanas o hasta la fecha que se determine que usted ha alcanzado la máxima mejoría médica, lo que ocurra primero.**
- Beneficios por Daños Permanente (IB por su sigla en inglés):Estos beneficios son proveídos cuando la lesión o enfermedad causa pérdida física, psicológica o funcional y la incapacidad existe después de la fecha de la máxima mejoría médica. [MMI] Un médico le asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje de incapacidad al cuerpo en su totalidad.
- Beneficios por Incapacidad Total Permanente (PTD por su sigla en inglés): Estos beneficios son proveídos cuando la lesión causa que usted sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por Fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

La tasa, cantidad, y duración de beneficios de reemplazo de salario son estipulados en la ley de compensación por accidentes de trabajo. **Si usted tiene preguntas sobre sus beneficios llame a su tasador(a) /ajustador(a) de reclamo o a la Oficina de Ayuda al Trabajador al 1-800-342-1741 Ext. 30027.**

### **Responsabilidades del Trabajador Lesionado**

#### **Comuníquese con el Empleador:**

- Contacte su supervisor/empleador inmediatamente para notificarle que sufrió una lesión o enfermedad en su trabajo.
- Provéela a su empleador una copia del Formulario Para Reportar el Estatus de su Caso y Tratamiento Médico (formulario médico para reportar el tratamiento/estado de su caso) (DWC25) [titulada en Inglés "Medical Treatment/Status Reporting Form (DWC25)"] después de cada cita médica.
- Vuelva a su lugar de empleo cuando su médico lo permita y su empleador le ofrezca un trabajo de acuerdo a sus limitaciones para evitar la suspensión de los beneficios de reemplazo de salario.

#### **Comuníquese con la compañía de seguros:**

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés "First Report of Injury or Illness" (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no esta de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíquese a su tasador(a)/ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, esta confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provée la declaración a la compañía de seguros.

# INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted está representado por un abogado, posiblemente su tasador(a) /ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

## Comuníquese con el Médico Autorizado por la Compañía de Seguros:

- Identifique todas las partes del cuerpo que están o potencialmente pueden ser dañadas, y sea específico(a) al identificar las áreas del dolor.
- Cumpla con sus citas médicas.
- Aclare su estado laboral durante sus citas antes de salir de la oficina del médico.
- Siga el plan recomendado por su médico.
- Pídale a su médico una copia del Reporte Médico Sobre el Estado/Tratamiento de su Caso (DWC25) [titulada en inglés, "Medical Treatment /Status Reporting Form (DWC25)"].
- Notifique a su médico de cualquier cambio de dirección o número de teléfono.
- Llame a la oficina del médico autorizado si usted necesita ver al médico antes de su próxima cita. Quizás el personal pueda anotar su nombre en una lista de cancelación y pueda conseguir una cita más pronto si otro paciente cancela su cita. Si no hay una cita disponible, y usted necesita ver un médico inmediatamente, por favor contacte su tasador(a)/ajustador(a) de reclamo o la Oficina de Ayuda al Trabajador.

## Responsabilidades de la Compañía de Seguros

- Disposición oportuna del tratamiento médico
- Pago oportuno de beneficios de reemplazo de salario
- Pago oportuno de facturas médicas
- Notificación oportuna de su reclamo a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamo. Esta información le será proveída por correo en una hoja titulada Notificación de Acción o Cambio (DWC4) [Titulado en inglés "Notice of Action/Change (DWC4)"] o en una Notificación de Negación (DWC12) [Titulado en inglés Notice of Denial (DWC12)].

## Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assistance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO 1-800-342-1741 Ext. 30027. Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir

# INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar. Usted puede localizar estas oficinas estatales visitando nuestra página de web: [http://www.fldfs.com/WC/organization/eao\\_offices.html](http://www.fldfs.com/WC/organization/eao_offices.html)

## **Servicios Proveido por el EAO incluyen:**

- Educar y proveer información sobre su reclamo.
- Asistirle a resolver desacuerdos referentes a su reclamo sin ningún costo para usted.
- Asistirle a entender los procedimientos para iniciar el proceso judicial y someter una petición de beneficios a la oficina de jueces de reclamaciones de compensación.

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados

Lesionados " en la página Web de la División de Compensación por Accidentes de Trabajo: [www.MyFloridaCFO.com/WC/employee/index.html](http://www.MyFloridaCFO.com/WC/employee/index.html)

Se pueden obtener las respuestas a preguntas que se hacen con frecuencia en: [www.MyFloridaCFO.com/WC/faq/faqwrkrs.html](http://www.MyFloridaCFO.com/WC/faq/faqwrkrs.html). Usted también puede someter sus preguntas específicas relacionadas con su reclamo al [wceao@MyFloridaCFO.com](mailto:wceao@MyFloridaCFO.com) y recibir la respuesta directamente por correo electrónico.

## **Estatuto de Limitaciones**

Una vez que usted se ha dañado en su trabajo o se da cuenta que su lesión es relacionada a su trabajo, usted tiene 30 días para reportar su lesión a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su demanda.

Generalmente, usted tiene dos años a partir de la fecha de su lesión o enfermedad para reclamar beneficios por accidentes de trabajo. La falta de reportar su lesión u enfermedad en el plazo de 30 días se puede utilizar como defensa contra su reclamo sin importar el estatuto de dos años de las limitaciones para archivar una reclamación. Su elegibilidad para beneficios de reemplazo de salario se puede terminar un año después de recibir el último cheque de beneficio de reemplazo de salario o del último tratamiento médico que fue autorizado.

## **Negación de Beneficios**

Si la compañía de seguro no le provee los beneficios que usted cree que tiene derecho a recibir, puede contactar a la Oficina de Ayuda al Trabajador (EAO). Aunque la EAO no provee consejos legales, nuestros especialistas contestarán preguntas sobre sus derechos y responsabilidades y posiblemente resuelvan problemas que usted tenga con su reclamo. Esta ayuda es gratis y disponible si contacta EAO al 1-800-342-1741 Ext. 30027.

## **Petición por Beneficios**

Para comenzar el procedimiento judicial para obtener beneficios que se le deben según la ley y no han sido proveídos por el empleador o la compañía de seguros, debe presentar el formulario Petición por Beneficios (titulado en inglés Petition for Benefits) a la Oficina de Jueces de Reclamos de Compensación. El formulario se puede obtener en el sitio: [www.jcc.state.fl.us/jcc/forms/.asp](http://www.jcc.state.fl.us/jcc/forms/.asp).

## **Servicios de Reempleo**

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo anterior, puede contactar al Departamento de Educación, División de Rehabilitación Vocacional en [www.rehabworks.org](http://www.rehabworks.org) o puede llamar al 850-245-3470 para recibir servicios de re-empleo gratis.

# INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

## Representación Legal

No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la División de Compensación por Accidentes de Trabajo no provee asesoramiento legal, la División contestará preguntas sobre sus derechos y responsabilidades y posiblemente podrá resolver problemas que usted pueda tener con su reclamo. La ayuda es gratis y está disponible si usted contacta la Oficina de Ayuda al Trabajador (EAO) al 1-800-342-1741 Ext. 30027.

## Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosas. El fraude de seguros por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta \$25,000.00 se pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al 1-800-378-0445 para reportar sospechas de fraude de seguro por accidentes de trabajo.

### **Limitación de responsabilidad**

*Esta publicación está siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ninguna circunstancia será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.*





## IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA

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

Please review your policy carefully. Should you have any questions concerning coverages, billings, additions or deletion, please contact your agent. Should you feel the need for additional information or wish to make a complaint, we offer the following number:

For information or to make a complaint, call  
1-800-328-2189





## CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Policy #: (TC2JUB-1112L07-9-14) Effective Date of Policy: 03-01-14

I am submitting a copy of my workplace safety program that meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

- |   |                             |
|---|-----------------------------|
| 1) Written safety policy and safety rules | 5) First aid                |
| 2) Safety inspections                     | 6) Accident investigation   |
| 3) Preventative maintenance               | 7) Necessary record keeping |
| 4) Safety training                        |                             |

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any misleading or untrue information. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that if I knowingly and willfully falsify or conceal a material fact, make a false, fictitious or fraudulent statement or representation; or make or use any false document knowing the document to contain any false, fictitious or fraudulent entry or statement to my carrier of workers compensation insurance under Section 442, Florida Statutes, I will be guilty of a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes, and will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence; and

I am also aware that if I, in any matter within the jurisdiction of the division, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent entry, that I commit a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes. Moreover, I understand that an employer who commits such an act will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

State of Florida

County of \_\_\_\_\_

Sworn to, or affirmed, and subscribed before me

this \_\_\_\_\_ day of \_\_\_\_\_

20 \_\_\_\_\_, by \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name and Title)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Expiration Date and Number)



## WORKERS' COMPENSATION GEORGIA

**DEAR POLICYHOLDER:**

RECENT LEGISLATIVE CHANGES IN THE WORKERS' COMPENSATION LAWS IN THE STATE OF GEORGIA MAY HAVE A SIGNIFICANT IMPACT ON YOUR RIGHTS AND DUTIES AS AN EMPLOYER.

ENCLOSED IS THE NEW "POSTING NOTICE" AND "BILL OF RIGHTS" FOR YOUR USE. THESE ARE REQUIRED BY LAW TO BE POSTED BY YOU IN A CONSPICUOUS PLACE WHERE WORKERS CAN READILY SEE IT.

## SOME IMPORTANT POINTS TO EXAMINE:

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation.

A worker injured on the job must select a doctor from a list. The minimum panel shall consist of at least four physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics. Further, this panel shall include one minority physician, whenever feasible. (See Rule 201 for definition of minority physician). One change of doctor, from the list, may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.



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## IMPORTANT NOTICE – COMPLAINTS – ILLINOIS

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

If you are having problems you may contact your insurance agent directly or you may contact the company at:

Mail: Consumer Affairs  
One Tower Square  
Hartford, CT 06183

Phone: (860) 277-1561 or

Email: [consumeraffairs@travelers.com](mailto:consumeraffairs@travelers.com)

The address of the consumer complaint division of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Consumer Division  
320 W Washington St  
Springfield, IL 62767

Complaints may also be filed electronically to the Illinois Department of Insurance at  
<https://insurance.illinois.gov/applications/ComplaintForms/default.aspx>







**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: (TC2JUB-1112L07-9-14)

## IMPORTANT NOTICE

RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT – ILLINOIS

The Illinois Religious Freedom Protection and Civil Union Act provides that persons of the same or opposite sex who enter into a civil union must be afforded the same obligations, protections, and legal rights as married persons. This law became effective June 1, 2011, and is designed to ensure that civil unions and marriage are treated identically under Illinois law. In accordance with law, this policy will be interpreted to provide the same benefits and protections to persons in a civil union or in a marriage.



W12N1E13

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002905



## NOTICE

Dear Policyholder:

Effective January 1, 1999, the State of New Jersey, Commissioner of Banking and Insurance approved the following change to your Workers' Compensation and Employers Liability Policy.

- \* The elimination of Endorsement WC 29 03 01, the New Jersey Part Two Limit of Liability Endorsement.
  - \* The inclusion of Endorsement WC 29 03 06, the New Jersey Part Two Employers Liability Endorsement.

The above revisions serve to:

- \* Impose a limit on our liability under Part Two, Employers Liability.
  - \* Recognize the litigious environment involving claims alleging discrimination, harassment etc. and discourage such activities in the workplace.

Note: these changes are mandatory and apply to every standard New Jersey Workers' Compensation and Employers Liability Insurance Policy.

**No coverage is provided by this policyholder notice nor can it be construed to replace any provision of your policy. You should read your policy and review your Information Page for complete information on coverage you are provided.**

If additional information is needed, please contact your producer or broker.



W29N5E99



# NOTICE

Dear Policyholder:

The enclosed Workers Compensation Policy has been issued to you showing two Information Pages. They both will reflect the total of your policy estimated premium. The reason for the two Information Pages for your account is because New Jersey requires its own Information Page. The New Jersey Information Page has its own version identifier different from the countrywide identifier.

There is absolutely no additional premium for the account due to the additional Information Page. We need this separation to handle statutory requirements and statistical separation of New Jersey Workers Compensation premium from the other states on the policy.

The addition of this New Jersey Information Page does not Add to or Subtract from any coverages that are on your policy.

Thank you for your understanding in this matter.



W29N6G07

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## RIGHTS AND DUTIES FORM – SIDE 1

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

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

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

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

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

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

---

Print Name

---

Employee Signature

---

Date

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

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

## **RIGHTS AND DUTIES FORM – SIDE 2**

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

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

# WORKERS' COMPENSATION INFORMATION

## Pennsylvania

### THANK YOU FOR YOUR BUSINESS

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

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

1. Forms – There are two forms that need to be signed by your employees, before an accident ever happens.

- A. **Workers Compensation Information Form.** Please have your employees sign this form when you receive this letter, and again at the time of any reported accident or incident. Be sure that this form is also signed by all newly hired employees. The two signatures (form signed at time of hire and form signed at time of reported accident) are required to comply with current guidelines set forth by the Pennsylvania Workers Compensation Bureau.
- B. **Pennsylvania Rights and Duties.** Please have your employees sign this form shortly after receiving your policy packet, as well as at the time of any workers compensation accident or incident. This assures that your employees treat with a recommended network medical provider for the first 90 days following an injury when you have posted a List of Network Providers.

2. List of Network Medical Providers – This is also known as a "panel" list.

- A. Benefits: Using a panel list provides you the opportunity to direct your employees for the first 90 days of a claim to a recommended network medical provider that is familiar with the workers compensation program, if you get the Rights and Duties signed. Using this panel list helps your employee to return to work and helps you by reducing the overall cost of the workers compensation claim.

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

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



## WORKERS' COMPENSATION INFORMATION Pennsylvania

**To all employees:**

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

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

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

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

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

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

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

[www.state.pa.us](http://www.state.pa.us), PA Keyword: workers comp.

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

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

## TEXAS

## NOTICE OF ACCIDENT PREVENTION SERVICES

Travelers is required by law to provide its policyholders with certain accident prevention services as required by the Texas Labor Code, § 411.066, at no additional charge and return-to-work coordination services as required by Texas Labor Code § 413.021.

If you would like more information, call Travelers loss control division at (214) 570-6675 (Dallas area) or (281) 606-8534 (Houston area) for accident prevention services or for return-to-work coordination services.

If you have any questions about this requirement, call the Division of Workers' Health and Safety, Texas Workers' Compensation Commission at 1-800-687-7080.

**Notice To Policy Recipient:**

If you are not the person directly responsible for the accident prevention activities of your company in Texas, please direct these safety services notices to the person directly responsible for accident prevention activities.





# State of Texas

## Important Loss Control Information

Texas Department of Insurance, Division of Workers' Compensation Rule 166.4(c)(2)(E) requires that workers' compensation insurance carriers solicit comments from each policyholder at least every 12 months, to determine the need for safety information or assistance. The attached Safety Services notice describes the services which are available to you at no additional charge, and where you may obtain them in the State of Texas.

If you need accident prevention assistance, have questions, or wish to bring an issue to our attention, phone us or write your comments below and either fax or mail this form to the Travelers Risk Control office listed below.

FAX # (214) 570-6690

Phone # (214) 570-6682

Travelers

1301 E. Collins Blvd.

Richardson, TX 75081

Attn: Risk Control

## Comments



Policy # (if known): \_\_\_\_\_

Insured Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone & FAX Number: \_\_\_\_\_

Completed By: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

W42M4H07



# SAFETY SERVICES

**Notice to policy recipient:** If you are not the person directly responsible for the accident prevention activities for your company, please direct this Safety Services notice to the person that is directly responsible for them.

## SAFETY IS OUR CONCERN

Thank you for purchasing your insurance from one of the writing companies owned or managed by The Travelers Companies, Inc. We appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns safety and accident prevention. Travelers Risk Control department has the experience, resources and capabilities to provide a range of safety services, including site surveys, phone consultations, as well as provide access to numerous safety-related materials.

We have experience in a variety of industries, some of which include manufacturing, wholesale and retail businesses, service organizations, technology-related business, oil and gas-based business, and the public sector.

Following are some examples of available safety services:

**Accident Prevention** – Our staff can help you identify present and potential hazards in your operations, premises and equipment, and recommend measures for reducing or eliminating these hazards.

**Analysis of Accident Causes** – Although you investigate and keep records of accidents, we are available to assist if needed.

**Safety Consultations** – Our Consultants can help you with special problems such as ergonomics and human factors.

These services are available upon request. See the remainder of this document for the Travelers' Risk Control office nearest you. **These phone numbers should not be used for questions regarding your policy or claims.**

**Industrial Hygiene/Health Services** – We have the facilities and resources to answer your questions concerning job related industrial hygiene/health issues and to measure exposure to industrial hygiene hazards.

**Safety Literature and Digital Media** – We can provide you with top-notch safety-related literature, CDs, DVDs, and videos to assist in your loss control efforts. Also, we can direct you to several vendors who are able to provide additional safety materials, including brochures, pamphlets and digital media.

**Safety Training** – We offer face-to-face classroom courses, as well as distance learning programs that explore the risks our policyholders face and ways for them to control losses.

**Return-To-Work Coordination** – We can assist you with several aspects of the post injury management process.

**Internet Website** – Visit our Risk Control website for access to our safety newsletters and other safety literature at: <http://www.travelers.com/riskcontrol>

This website also has links to other safety-related Internet sites.

**Please note: For ALL loss control assistance requests, please contact your local office directly, which is listed on one of the following pages.**

## SAFETY IS YOUR CONCERN

U.S. employers spend billions of dollars each year on the direct and indirect costs of work-related accidents. Dollar figures can't begin to reflect the pain and suffering of an injured worker and his or her family. But they do give some indication of the multiple consequences of a job-related accident... loss of time, interrupted production, damaged materials and equipment, the expense of retraining or replacing an injured worker, possible legal action from government regulatory agencies, and increased insurance costs.

It makes good sense for both employers and their employees to actively participate in a sound accident prevention program. The success of such a program depends to a large extent on your commitment to safety procedures and accident prevention techniques. Safety is a management concern. Maybe we can help.

You may want to consider the following "Safety Checkpoints" as you evaluate your organization's safety activities:

### SELF-INSPECTION PROGRAM:

- Do you conduct periodic surveys of premises?... equipment?... operations?

### SELF-INSPECTION PROGRAM (continued):

- Do you analyze each job to find inherent hazards?
- If you discover hazards, do you follow up with immediate corrective action?
- Do you monitor such action to make sure it is implemented and effective?

### ACCIDENT INVESTIGATION:

- Do you investigate each accident?...determine the cause?
- Do you take immediate steps to prevent a recurrence?
- Do you keep records of accident investigations and follow-up measures?
- Do you complete accident statistics and analyze trends?

### EDUCATION AND TRAINING:

- Do you take the time to train each of your employees to perform tasks safely?
- Do more-experienced employees receive training to correct bad habits that have developed over time?
- Do all employees understand that safety is an important part of their jobs?

**Please call these numbers**  
**FOR SAFETY SERVICES ONLY**

**For all other inquiries please contact your agent, underwriter or claim representative**

**ALABAMA**  
**Birmingham**

3000 Riverchase Galleria  
Ste. 600  
Birmingham, AL 35244  
(678) 317-7708  
Claims: 1-800-238-6214

**ALASKA**  
**Portland, OR**

4000 SW Kruse Place, Suite 100  
Lake Oswego, OR 97035  
(503) 534-4276

**ARIZONA**  
**Phoenix**

2401 W Peoria Ave., Suite 130  
Phoenix, AZ 85029  
(720) 200-8355

**ARKANSAS**  
**Richardson, TX**

1301 E. Collins Blvd  
Richardson, TX 75081  
(214) 570-6675

**CALIFORNIA**  
**Diamond Bar**

21688 Gateway Center Drive  
P.O. Box 6512  
Diamond Bar, CA 91765-8512  
Risk Control: (714) 620-0682  
Claims: (909) 612-3000

**CALIFORNIA**  
**Glendale**

700 N. Central Avenue, 4th Floor  
P.O. Box 1840  
Glendale, CA 91209  
Risk Control: (714) 620-0682  
Claims: (909) 612-3000

**CALIFORNIA**  
**Los Angeles**

888 South Figueroa St., Ste. 500  
Los Angeles, CA 90017  
(714) 620-0682  
Risk Control: (714) 620-0682  
Claims: (909) 612-3000

**CALIFORNIA**  
**Sacramento**

11070 White Rock Road, Suite 130  
Rancho Cordova, CA 95670  
Risk Control: (916) 852-5245  
Claims: (800) 727-3995

**CALIFORNIA**  
**San Diego**

9325 Sky Park Court, Ste. 220  
San Diego, CA 92123  
(714) 612-0682

**CALIFORNIA**  
**Walnut Creek**

225 Lennon Lane, Ste. 105  
P.O. Box 8090  
Walnut Creek, CA 94596-8090  
Risk Control: (925) 945-4171  
Claims: (800) 842-7354

**COLORADO**  
**Denver**

6060 S. Willow Dr. #300  
Greenwood Village, CO 80111  
(720) 200-8355  
Claims: 720-200-8100

**CONNECTICUT**  
**Hartford**

300 Windsor Street  
Hartford, CT 06120  
(860) 954-3741  
Claims: (860) 954-5190

**DELAWARE**  
**Washington, DC**

10 Sentry Parkway, Suite 300  
Blue Bell, PA 19422  
(215) 274-1610  
Claims: 1-800-368-3562

**DISTRICT OF COLUMBIA**  
**Washington, DC**

14200 Park Meadow Dr.  
Chantilly, VA 20151  
(571) 287-6232  
Claims: 1-800-368-3562

**FLORIDA**  
**Orlando**

2420 Lakemont Dr  
Orlando, FL 32814  
(407) 388-3307  
Claims: 407-388-2400

**GEORGIA**  
**Atlanta**

1000 Windward Concourse  
Alpharetta, GA 30005  
(678) 317-7708  
Claims: 800-238-6214

**HAWAII**  
**Orange, CA**

333 City Blvd. W  
Suite 1100  
Orange, CA 92868  
(714) 620-0682

**IDAHO**  
**Portland, OR**

4000 SW Kruse Place, Suite 100  
Lake Oswego, OR 97035  
(503) 534-4276

**ILLINOIS**  
**Chicago**

200 North LaSalle Street  
Suite 2200  
Chicago, IL 60601  
(630) 961-8074  
Claims: 800-842-6172

**ILLINOIS**  
**Naperville**

215 Shuman Boulevard  
P.O. Box 3208  
Naperville, IL 60566  
(630) 961-8074  
Claims: 800-842-6172

**INDIANA**  
**Indianapolis**

Suite 300  
6081 East 82nd Street  
Indianapolis, IN 46250  
(317) 845-1479  
Claims: 800-238-6210

**IOWA**  
**Des Moines**

7101 Vista Dr.  
West Des Moines, IA 50266-9313  
(651) 310-4422  
Claims: 800-255-5072

**KANSAS**  
**Kansas City**

7465 West 132nd  
Overland Park, KS 66213  
(913) 685-5109

**KENTUCKY**  
**Louisville**

Suite 150  
303 N Hurstbourne Pkwy  
Louisville, KY 40222  
(502) 429-7390  
Claims: 800-238-6210

**Please call these numbers**  
**FOR SAFETY SERVICES ONLY**

**For all other inquiries please contact your agent, underwriter or claim representative**

**LOUISIANA**

**New Orleans**

3838 N. Causeway, Suite 2700  
 Metairie, LA 70002  
 P.O. Box 61479  
 New Orleans, LA 70161-1479  
 (504) 832-7562  
 Claims: 800-842-2556

**MAINE**

**Portland, ME**

207 Larrabee Road, Suite 3  
 Westbrook, ME 04092  
 (207) 857-2021

**MARYLAND**

**Washington, DC**

14200 Park Meadow Dr.  
 Chantilly, VA 20151  
 (571) 287-6232  
 Claims: 1-800-368-3562

**MASSACHUSETTS**

**Boston**

100 Summer Street, Suite 201A  
 Boston, MA 02110  
 (781) 817-8370  
 Claims: 800-832-7839

**MASSACHUSETTS**

**Hudson**

1 Cabot Road  
 Suite 250  
 Hudson, MA 01749  
 (781) 817-8370  
 Claims: 800-832-7839

**MASSACHUSETTS**

**Braintree**

350 Granite Street  
 Suite 1201  
 Braintree, MA 02184  
 (781) 817-8370  
 Claims: 800-832-7839

**MICHIGAN**

**Grand Rapids**

3777 Sparks Ave. SE, Ste. 200  
 P.O. Box 3010  
 Grand Rapids, MI 49501-0323  
 (248) 312-7301  
 Claims: 800-238-6210

**MICHIGAN**

**Troy**

1301 W. Long Lake Rd., Ste. 300  
 Troy, MI 48098  
 (248) 312-7301  
 Claims: 800-238-6210

**MINNESOTA**

**St. Paul**

385 Washington St., MC 104P  
 St. Paul, MN 55102  
 (651) 310-4422  
 Claims: 800-842-3073

**MISSISSIPPI**

**Jackson**

1080 River Oaks Dr  
 Ste B-200  
 Flowood, MS 39232  
 (601) 936-8212  
 Claims: 1-800-342-4064

**MISSOURI**

**Maryland Heights**

940 West Port Plaza, Suite 450  
 Maryland Heights, MO 63146  
 (913) 685-5109  
 Claims: 800-842-9621

**Kansas City**

7465 West 132nd  
 Overland Park, KS 66213  
 (913) 685-5109  
 Claims: 800-255-5072

**Missouri Workers'**

**Compensation Plan (MWCP)**

1000 Walnut Street  
 Kansas City, MO 64199  
 (816) 391-1123

**MONTANA**

**Portland, OR**

4000 SW Kruse Place, Suite 100  
 Lake Oswego, OR 97035  
 (503) 534-4276

**NEBRASKA**

**Omaha**

11516 Miracle Hills Dr., St. 400  
 Omaha, NE 68154  
 (651) 310-4422  
 Claims: 800-255-5072

**NEVADA**

**Las Vegas**

1850 E Flamingo, Suite 202  
 Las Vegas, NV 89119  
 (702) 669-4746  
 Claims: 702-479-4200

**NEW HAMPSHIRE**

**Portland, ME**

207 Larrabee Road, Suite 3  
 Westbrook, ME 04092  
 (207) 857-2021

**NEW JERSEY**

**Morristown**

445 South Street  
 Morristown, NJ 07960  
 (973) 631-7015  
 Claims: 1-800-842-2475

**NEW JERSEY**

**Marlton**

Lake Center Exec Park Building 30  
 Suite 110  
 Marlton, NJ 08053  
 (856) 703-2323  
 Claims: 800-842-2475

**NEW MEXICO**

**Phoenix**

2401 W Peoria Ave., Suite 130  
 Phoenix, AZ 85029  
 (720) 200-8355  
 Claims: 602-861-8600

**NEW YORK**

**Albany**

900 Watervliet-Shaker Road  
 Albany, NY 12205  
 (315) 424-7231  
 Claims: 800-842-2475

**NEW YORK**

**Buffalo**

60 Lakefront Blvd.  
 P.O. Box 242  
 Buffalo, NY 14240-0242  
 (315) 424-7231  
 Claims: 800-842-2475

**NEW YORK**

**Jericho-Long Island**

Two Jericho Plaza  
 Jericho, NY 11753  
 (516) 933-3932  
 Claims: 800-842-2475

**NEW YORK**

**New York**

485 Lexington Ave.  
 New York, NY 10017-2630  
 (516) 933-3932  
 Claims: 1-800-842-2475

**Please call these numbers**  
**FOR SAFETY SERVICES ONLY**

**For all other inquiries please contact your agent, underwriter or claim representative**

<b>NEW YORK</b> <b>Rochester</b> 75 Town Centre Drive P.O. Box 23235 Rochester, NY 14692-3235 (315) 424-7231 Claims: 1-800-842-2475	<b>PENNSYLVANIA</b> <b>Philadelphia</b> 10 Sentry Parkway, Suite 300 Blue Bell, PA 19422 (215) 274-1610 Claims: 800-832-0606	<b>UTAH</b> <b>Denver, CO</b> 6060 S. Willow Drive #300 Greenwood Village, CO 80111 (720) 200-8306 Claims: 800-453-3025
<b>NEW YORK</b> <b>Syracuse</b> 440 South Warren Street P.O. Box 4963 Syracuse, NY 13221-4963 (315) 424-7231 Claims: 800-842-2475	<b>PENNSYLVANIA</b> <b>Pittsburgh</b> 800 Two Chatham Center Pittsburgh, PA 15219-2505 (412) 338-3082 Claims: (412) 338-3000	<b>VERMONT</b> <b>Hartford, CT</b> 300 Windsor Street Hartford, CT 06120 (860) 954-5190
<b>NORTH CAROLINA</b> <b>Charlotte</b> 11440 Carmel Commons Blvd. P.O. Box 473500 Charlotte, NC 28247-3500 (704) 540-3438 Claims: (704) 544-3500	<b>PENNSYLVANIA</b> <b>Reading</b> 1105 Berkshire Blvd. P.O. Box 13426 Wyomissing, PA 19612-3426 (215) 274-1610 Claims: 800-832-0606	<b>VIRGINIA</b> <b>Richmond</b> 300 Arboretum Place P.O. Box 26426 Richmond, VA 23260-6426 (804) 330-6063 Claims: (804) 330-6000
<b>NORTH CAROLINA</b> <b>Raleigh</b> 4504 Emperor Blvd. Durham, NC 27703 (919) 474-4811 Claims: (704) 544-3500	<b>RHODE ISLAND</b> <b>Braintree</b> 350 Granite Street Suite 1201 Braintree, MA 02184 (781) 817-8370 Claims: 800-832-7839	<b>Washington, DC</b> 14200 Park Meadow Dr. Chantilly, VA 20151 (571) 287-6232 Claims: 800-368-3562
<b>NORTH DAKOTA</b> <b>St. Paul, MN</b> 385 Washington St., MC 104P St. Paul, MN 55102 (651) 310-4422 Claims: 800-842-3073	<b>SOUTH CAROLINA</b> <b>Charlotte</b> 11440 Carmel Commons Blvd. P.O. Box 473500 Charlotte, NC 28247-3500 (704) 540-3438 Claims: 704-544-3500	<b>WASHINGTON</b> <b>Seattle</b> 1501 4th Avenue, Suite 400 Seattle, WA 98101 (206) 464-3463
<b>OHIO</b> <b>Cincinnati</b> 895 Central Ave., Ste. 800 Cincinnati, OH 45202 (317) 845-1479 Claims: 800-238-6210	<b>SOUTH DAKOTA</b> <b>St. Paul, MN</b> 385 Washington St. St. Paul, MN 55102 (651) 310-4422 Claims: 800-842-3073	<b>WEST VIRGINIA</b> <b>Pittsburgh, PA</b> 800 Two Chatham Center Pittsburgh, PA 15219-2502 (412) 338-3082 Claims: (443) 353-1000
<b>OHIO</b> <b>Cleveland</b> Skylight Office Tower 1660 W. 2nd St., Ste. 500 Cleveland, OH 44113-1454 (317) 845-1479 Claims: 800-238-6210	<b>TENNESSEE</b> <b>Franklin</b> 6640 Carothers Pkwy, Suite 300 Franklin, TN 37067 (615) 660-6036 Claims: (615) 660-6000	<b>WISCONSIN</b> <b>Milwaukee</b> 13935 Bishops Drive, Suite 200 Brookfield, WI 53005 (262) 825-9203 Claims: 800-842-6172
<b>OKLAHOMA</b> <b>Tulsa</b> 9820 East 41st St., Suite 401 P.O. Box 3510 Tulsa, OK 74101 (918) 624-2730	<b>TEXAS</b> <b>Dallas</b> 1301 E Collins Blvd., Suite 300 Richardson, TX 75081 (214) 570-6675 Claims: 214-570-6000	<b>WYOMING</b> <b>Denver, CO</b> 6060 S. Willow Drive #300 Greenwood Village, CO 80111 (720) 200-8306
<b>OREGON</b> <b>Portland</b> 4000 SW Kruse Place, Suite 100 Lake Oswego, OR 97035 (503) 534-4276 Claims: 800-698-6883	<b>TEXAS</b> <b>Houston</b> 4650 Westway Park Blvd., Suite 350 Houston, TX 77041 (281) 606-8534 Claims: 800-235-3610	



**PENNSYLVANIA  
IMPORTANT POLICYHOLDER INFORMATION  
NOTICE OF ACCIDENT & ILLNESS PREVENTION SERVICES**

**IMPORTANT NOTE: THIS NOTICE IS PROVIDED TO YOU IN ACCORDANCE WITH A REGULATORY REQUIREMENT OF THE COMMONWEALTH OF PENNSYLVANIA THAT APPLIES BECAUSE OF YOUR OPERATIONS IN PENNSYLVANIA. IT IS NOT PART OF YOUR POLICY WITH US NOR DOES IT CHANGE YOUR WORKERS COMPENSATION COVERAGE PROVIDED BY US.**

**ACCIDENT AND ILLNESS PREVENTION SERVICES**

Pennsylvania Statute requires us to provide our workers' compensation policyholders with certain accident and illness prevention services.

Travelers' Risk Control department has a sufficient number of qualified loss control personnel to assist you in maintaining a safe and healthy working environment.

Accident and illness prevention services that are available to you upon request include:

1. Physical surveys of your work areas to help identify potential accident hazards or existence of harmful hazards.
2. Providing or proposing corrective actions in the area of industrial hygiene services.
3. Providing or proposing corrective actions in the area of industrial health services.
4. Accident and illness prevention training programs, which may include training for safety committee members.
5. Consultations regarding specific safety and health problems and hazard abatement programs and techniques related to the introduction of new equipment or new materials.

These services are available upon request and as appropriate to the nature of your operations. For more information on our accident and illness prevention services, see the attached Safety Services notice. If you need assistance or further information on our Risk Control services call or write the closest Risk Control office listed on the attached Safety Services notice. You may also visit us online at <http://www.travelers.com/riskcontrol>.

**CERTIFIED WORKPLACE SAFETY COMMITTEE PREMIUM DISCOUNT**

Pennsylvania statute makes available to insureds that form a certified workplace safety committee a 5% workers' compensation premium discount. Your agent or broker can provide you with additional information on this program or can direct you to the appropriate Travelers underwriting contact.

**IMPORTANT: If you receive notification from the Commonwealth of Pennsylvania Department of Labor and Industry Health and Safety Division stating that your application for certification of your workplace safety committee has been granted, you must forward a copy of the certification letter to Travelers in order to receive the 5% workers' compensation premium credit. Please mail or fax the certification letter to:**

Travelers Insurance  
1 Cabot Road, Suite 250  
Hudson, MA 01749  
Attn: Craig Russell - Risk Control  
FAX 888-401-2579



## Important Notice to Policy Holders in California

Your policy contains the following form:

WC 04 03 17 00 – Employee Insured by General Employer

If, in the conduct of your business in California, you have employees provided to you pursuant to an agreement with another employer (the "General Employer"), this endorsement is intended to prevent your workers' compensation policy from responding to work related injuries to such employees in the event the General Employer's workers' compensation carrier becomes insolvent. Such an agreement may exist, for example, if you hire temporary employees through an agency, or contract with an employee leasing company.

In order for exclusion WC 04 03 17 00 to be effective, you must countersign the form. Sign and return the form if you want to avoid this exposure under your policy, if you have a valid and enforceable agreement with the General Employer in which the General Employer has agreed to obtain workers' compensation coverage for the employees, and if the General Employer has obtained such workers' compensation coverage. With this exclusion in place on your policy, an injured employee you hired through a temporary agency or under contract with an employee leasing company would submit the claim to the California Insurance Guarantee Association (CIGA) in the event the temporary agency's or employee leasing company's workers' compensation carrier becomes insolvent. Without the signed exclusion, CIGA may not pay such claims, resulting in increased exposure under your policy.

Signed forms should be sent to your agent or broker.







WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 04 03 17 (00)

POLICY NUMBER: (TC2JUB-1112L07-9-14)

**ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE**  
**Employee Insured by General Employer Excluded**

The insurance under this policy is limited as follows:

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

**NO LIABILITY FOR  
EMPLOYEE INSURED BY  
GENERAL EMPLOYER**

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

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

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

Countersigned By \_\_\_\_\_

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Insurance Company

Countersigned by \_\_\_\_\_



**POLICYHOLDER NOTICE**  
**SHORT RATE CANCELLATION**  
**CALIFORNIA INSURANCE CODE SECTION 481**

CA Insurance Code Section 481 requires that where an insurance policy includes a provision to refund premium on anything other than a pro rata basis, including the assessment of cancellation fees, the insurer must disclose that fact to the policyholder in writing prior to, or concurrent with, the proposal or quote prior to each renewal. The disclosure must include the actual or maximum fees or penalties to be applied. The WCIRB also created a Short Rate Cancelation Endorsement which complements the disclosure requirement. This requirement applies to insurance policies issued or renewed on or after January 1, 2012.

In order to respond to this insurance code requirement we have created this Policyholder Notice to disclose our use of short rate calculations as described in the California Short Rate Cancellation Endorsement included in the policy.



W04N2H12

Page 1 of 1

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