TRAVELERS

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

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

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

A Custom Insurance Policy Prepared for:

CRAFT BEER COMPANY
2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: UB-2L039306-20-14-G

NJ TAX IDENTIFICATION NO.:

RENEWAL OF (UB-2L039306-19-14-G)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA
A Stock Company

NCCI CO CODE: 13579

1.

INSURED:
CRAFT BEER COMPANY
2501 SOUTHWEST BLVD
KANSAS CITY, MO 64108

PRODUCER:
LOCKTON COMPANIES LLC
444 W 47TH ST STE 900
KANSAS CITY, MO 64112-1906

Insured is **A CORPORATION**

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

2. The policy period is from **12-31-20** to **12-31-21** 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:
AR AZ CA CO CT DC FL GA HI IA ID IL IN KS KY MA MD MN MO MT NC NE NJ NM NV NY OK OR PA RI SD TN TX UT VA WI

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

Bodily Injury by Accident:	$	1,000,000	Each Accident
Bodily Injury by Disease:	$	1,000,000	Policy Limit
Bodily Injury by Disease:	$	1,000,000	Each Employee

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

AL DE LA ME MI MS NH SC 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: 01-04-21 AW
OFFICE: KANSAS CITY MO 095
PRODUCER: LOCKTON COMPANIES LLC 54274

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION SCHEDULE:

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

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 2082 NAICS: 111199

		STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	$	997733
LOSS CONSTANT		20
PREMIUM DISCOUNT		61749
0900-48 EXPENSE CONSTANT		220
TERRORISM		8149
CAT (OTHER THAN CERT ACTS OF TERRORISM)		779
TOTAL ESTIMATED PREMIUM		945152
TAXES AND SURCHARGES		38250
DEPOSIT AMOUNT DUE		983402

Minimum Premium: $ 704 EMPLOYERS LIABILITY MINIMUM: $150

STOPGAP MINIMUM: $300

DATE OF ISSUE: 01-04-21 AW
OFFICE: KANSAS CITY MO 095
PRODUCER: LOCKTON COMPANIES LLC 54274 COUNTERSIGNED-AGENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-AR**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY AR- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00 DUVEL MOORTGAT USA, LTD AR- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.10	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

AR MANUAL PREMIUM $ 0

WAIVER OF SUBROGATION	$	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		0
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM		0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		0
-6.20% PREMIUM DISCOUNT(0064)		0
TOTAL ESTIMATED PREMIUM		0
TOTAL PREMIUM		0
DEPOSIT AMOUNT DUE		0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-AZ**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY 17626 N 43RD ST PHOENIX , AZ 85032 NAICS: 111199				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	99882.00	0.24	240

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	144	0.020	3

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
AZ- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	490000.00	0.24	1176

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	706	0.020	14

AZ MANUAL PREMIUM $ 1416

-40.00% COMPANY DEVIATION CREDIT(9037)	$	-566
WAIVER OF SUBROGATION		17
1.10% EMPL. LIAB. INCREASED LIMITS(9812)		10
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		877
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM		851
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		851
-10.80% PREMIUM DISCOUNT(0063)		-92
TERRORISM(9740)		59
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		59
TOTAL ESTIMATED PREMIUM		877
TOTAL PREMIUM		877
DEPOSIT AMOUNT DUE		877

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA 090 004

INSURED'S NAME: CRAFT BEER COMPANY **13579-CA**

RATE BUREAU ID: 005424551

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
CA- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
CA- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	568711.00	0.59	3355

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 99 03 76 A	0930	3355	0.020	67

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
620 MCCURRAY RD BUELLTON , CA 93427 NAICS: 111199				
BREWERIES--VOLUNTARY COMP	2121	IF ANY	5.21	0
BREWERIES	2121	10000000.00	5.21	521000
STORES: STORES-WINE, BEER OR SPIRITS-RETAIL	8060	285000.00	3.19	9092
SALESPERSONS-OUTSIDE	8742	7700000.00	0.59	45430
CLERICAL OFFICE EMPLOYEES NOC	8810	4500000.00	0.42	18900
VENDING CONCESSIONAIRES-DISPENSING FOOD, DRINKS, CANDY, ETC, AT BALL PARKS, RACE TRACKS, THEATERS AND EXHIBITIONS	9079	2550000.00	5.22	133110

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 99 03 76 A	0930	727532	0.020	14551

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

CA MANUAL PREMIUM $ 730887

WAIVER OF SUBROGATION	$ 14618
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	745505
EXPERIENCE MODIFICATION:1.18 MODIFIED PREMIUM	879696
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	879696
-6.20% PREMIUM DISCOUNT(0064)	-54541
TERRORISM(9740)	5121
TOTAL ESTIMATED PREMIUM	830276
1.704% WC ADMIN REVOLVING FUND ASSESSMENT	14147
0.335% STATE FRAUD SURCHARGE	2781
0.127% UNINSURED EMPLOYERS BENEFIT TRUST FUND ASST	1054
0.482% SUBSEQUENT INJURY BENEFIT TRUST FUND ASST	4002
0.391% OCCUPATIONAL SAFETY & HEALTH FUND ASSESSMENT	3246
0.381% LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT	3163
TOTAL PREMIUM	858669
DEPOSIT AMOUNT DUE	858669

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **12432-CO**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY CO- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	197600.00	0.15	296

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	296	0.020	6

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
CO- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	650000.00	0.15	975

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	975	0.020	20

CO MANUAL PREMIUM $ 1271

WAIVER OF SUBROGATION	$ 26
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	14
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	1311
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	1272
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1272
-6.20% PREMIUM DISCOUNT(0064)	-79
TERRORISM(9740)	34
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	77
TOTAL ESTIMATED PREMIUM	1304
TOTAL PREMIUM	1304
DEPOSIT AMOUNT DUE	1304

TRAVELERS

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HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-CT**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY CT- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.23	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
CT- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	8336.00	0.23	19

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	19	0.020	0

CT MANUAL PREMIUM $ 19

WAIVER OF SUBROGATION	$ 0
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	19
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	18
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	18
-6.20% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	2
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	1
TOTAL ESTIMATED PREMIUM	20
2.25% CT SECOND INJURY FUND SURCHARGE	0
2.30% CT WC FUND ASSESSMENT (STATE ACT)	0
4.10% CT WC FUND ASSESSMENT (FEDERAL ACT)	0
TOTAL PREMIUM	20
DEPOSIT AMOUNT DUE	20

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-DC**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY DC- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	304857.00	0.09	274

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	274	0.020	5

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
DC- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	125000.00	0.09	113

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	113	0.020	2

DC MANUAL PREMIUM $ 387

WAIVER OF SUBROGATION	$ 7
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	398
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	387
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	387
-6.20% PREMIUM DISCOUNT(0064)	-24
TERRORISM(9740)	296
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	43
TOTAL ESTIMATED PREMIUM	702
0.91% DC POLICYHOLDER SURCHARGE	7
TOTAL PREMIUM	709
DEPOSIT AMOUNT DUE	709

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

INSURED'S NAME: CRAFT BEER COMPANY **12637-FL**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY FL- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	208312.00	0.35	729

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	729	0.030	22

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

FL MANUAL PREMIUM $ 729

WAIVER OF SUBROGATION	$ 22
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	10
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	761
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	738
-10.80% PREMIUM DISCOUNT(0063)	-80
TERRORISM(9740)	21
TOTAL ESTIMATED PREMIUM	679
1.00% FL WORKERS COMP INS GUARANTY ASSOCIATION SURCHARGE	7
TOTAL PREMIUM	686
DEPOSIT AMOUNT DUE	686

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **11347-GA**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY GA- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	58943.00	0.20	118

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	118	0.020	2

DATE OF ISSUE: **01-04-21 AW**

SCHEDULE NO: **1** OF **2**

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

GA MANUAL PREMIUM $ 118

WAIVER OF SUBROGATION	$ 2
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	121
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	117
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	117
-6.20% PREMIUM DISCOUNT(0064)	-7
TERRORISM(9740)	4
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	7
TOTAL ESTIMATED PREMIUM	121
TOTAL PREMIUM	121
DEPOSIT AMOUNT DUE	121

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-HI**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00 DEPARTMENT OF LABOR IDENTIFIER 0007791208 FIRESTONE WALKER, INC. HI- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	66000.00	0.46	304

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	304	0.020	6

HI MANUAL PREMIUM $ 304

WAIVER OF SUBROGATION	$ 6
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	313
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	304
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	304
-6.20% PREMIUM DISCOUNT(0064)	-19
TERRORISM(9740)	7
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	7
TOTAL ESTIMATED PREMIUM	299
TOTAL PREMIUM	299
DEPOSIT AMOUNT DUE	299

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

INSURED'S NAME: CRAFT BEER COMPANY **12637-IA**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY IA- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00 DUVEL MOORTGAT USA, LTD IA- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	225219.00	0.47	1059

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	900	0.020	18

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 464250234 ENTITY CD 001 00 CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 464250234 ENTITY CD 001 00 (CONT'D)				
IA- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.47	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

IA MANUAL PREMIUM $ 1059

-15.00% COMPANY DEVIATION CREDIT(9037)	$ -159
WAIVER OF SUBROGATION	18
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	10
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	928
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	900
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	900
-10.80% PREMIUM DISCOUNT(0063)	-97
TERRORISM(9740)	23
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	23
TOTAL ESTIMATED PREMIUM	849
TOTAL PREMIUM	849
DEPOSIT AMOUNT DUE	849

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **11223-ID**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
ID- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	80000.00	0.42	336

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	336	0.020	7

ID MANUAL PREMIUM $ 336

WAIVER OF SUBROGATION	$ 7
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	347
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	337
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	337
-10.80% PREMIUM DISCOUNT(0063)	-36
TERRORISM(9740)	8
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	8
TOTAL ESTIMATED PREMIUM	317
TOTAL PREMIUM	317
DEPOSIT AMOUNT DUE	317

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

INSURED'S NAME: CRAFT BEER COMPANY **12637-IL**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 464250234 ENTITY CD 001 00 CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV IL- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	180829.00	0.18	325
CLASSIFICATION	**CODE**	**WAIVER PREMIUM BASIS**	**RATE**	**ESTIMATED ANNUAL PREMIUM**
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	325	0.020	7
CLASSIFICATION	**CODE**	**PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION**	**RATES PER $100 OF REMUNERATION**	**ESTIMATED ANNUAL PREMIUM**
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC. IL- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	285000.00	0.18	513

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	513	0.020	10

IL MANUAL PREMIUM $ 838

WAIVER OF SUBROGATION	$ 17
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	12
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	867
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	841
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	841
-6.20% PREMIUM DISCOUNT(0064)	-52
TERRORISM(9740)	93
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	47
TOTAL ESTIMATED PREMIUM	929
1.01% IL WC COMM OP FUND SURCHARGE	10
TOTAL PREMIUM	939
DEPOSIT AMOUNT DUE	939

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-IN**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
359 S. SPENCER AVE NDIANAPOLIS , IN 46219 NAICS: 111199				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.11	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

IN MANUAL PREMIUM $ 0

WAIVER OF SUBROGATION	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	0
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-6.20% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
1.0083 SECOND INJURY FUND SURCHARGE(0935)	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-KS**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY KS- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	85000.00	0.13	111

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 99 03 J9 00	0930	111	0.020	2

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
KS- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	119046.00	0.13	155

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 99 03 J9 00	0930	155	0.020	3

KS MANUAL PREMIUM $ 266

WAIVER OF SUBROGATION	$ 5
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	274
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	266
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	266
-6.20% PREMIUM DISCOUNT(0064)	-17
TERRORISM(9740)	8
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	17
TOTAL ESTIMATED PREMIUM	274
TOTAL PREMIUM	274
DEPOSIT AMOUNT DUE	274

TRAVELERS

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HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-KY**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
KY- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.21	0

KY MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-6.20% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
6.41% KY SPECIAL FUND ASSESSMENT	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

INSURED'S NAME: CRAFT BEER COMPANY **12637-MA**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-19 **MA BUREAU FILE NO: 911620235**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
MA- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
MA- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	46387.00	0.10	46

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	46	0.020	1

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
MA- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	IF ANY	0.10	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

MA MANUAL PREMIUM $ 46

WAIVER OF SUBROGATION	$ 1
2.00% EMPL. LIAB. INCREASED LIMITS(9812)	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	48
EXPERIENCE MODIFICATION:0.94 MODIFIED PREMIUM	45
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	45
0% ARAP MODIFICATION PROGRAM(0277)	0
-10.80% PREMIUM DISCOUNT(0063)	-5
0% LOSS CONSTANT(0032)	20
TERRORISM(9740)	14
TOTAL ESTIMATED PREMIUM	74
3.51% DIA ASSESSMENT	2
TOTAL PREMIUM	76
DEPOSIT AMOUNT DUE	76

TRAVELERS

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HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-MD**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY MD- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	21510.00	0.20	43

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	43	0.020	1

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
MD- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	285000.00	0.20	570

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	570	0.020	11

MD MANUAL PREMIUM $ 613

WAIVER OF SUBROGATION	$ 12
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	631
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	612
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	612
-6.20% PREMIUM DISCOUNT(0064)	-38
TERRORISM(9740)	126
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	31
TOTAL ESTIMATED PREMIUM	731
TOTAL PREMIUM	731
DEPOSIT AMOUNT DUE	731

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-MN**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
STATE UNEMPLOYMENT IDENTIFIER 000431497917				
BOULEVARD BREWING COMPANY				
MN- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00				
STATE UNEMPLOYMENT IDENTIFIER 000431497917				
DUVEL MOORTGAT USA, LTD				
MN- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	109032.00	0.25	273

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION	0930	273	0.020	5
SEE ENDT WC 00 03 13 00				

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 811046925 ENTITY CD 005 00				
STATE UNEMPLOYMENT IDENTIFIER 000431497917				
FIRESTONE WALKER, INC.				

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
MN- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	IF ANY	0.25	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

MN MANUAL PREMIUM $ 273

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 3
WAIVER OF SUBROGATION	5
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	281
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	273
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	273
-6.20% PREMIUM DISCOUNT(0064)	-17
TERRORISM(9740)	8
TOTAL ESTIMATED PREMIUM	264
5.02% SPECIAL FUND SURCHARGE	14
TOTAL PREMIUM	278
DEPOSIT AMOUNT DUE	278

TRAVELERS

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **12432-MO**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
2501 SOUTHWEST BLVD				
KANSAS CITY , MO 64108				
NAICS: 111199				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
2501 SOUTHWEST BLVD				
KANSAS CITY , MO 64108				
NAICS: 111199				
CLERICAL OFFICE EMPLOYEES NOC--VOLUNTARY COMP	**8810**	**IF ANY**	**0.09**	**0**
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**IF ANY**	**0.09**	**0**

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	**0930**	**0**	**0.020**	**0**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				

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POLICY NUMBER: UB-2L039306-20-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 463956867 ENTITY CD 002 00 (CONT'D)				
MO- NO BUSINESS LOCATION				
BREWERY & DRIVERS	2121	3241068.00	0.99	32087
STORE: RETAIL NOC	8017	277000.00	1.10	3047
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.20	0
CLERICAL OFFICE EMPLOYEES NOC	8810	188308.00	0.09	169
BAR, DISCOTHEQUE, LOUNGE, NIGHT CLUB OR TAVERN	9084	1103174.00	0.94	10370

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	45673	0.020	913

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
MO- NO BUSINESS LOCATION				
BREWERY & DRIVERS	2121	808238.00	0.99	8002
STORE: RETAIL NOC	8017	IF ANY	1.10	0
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	1246106.00	0.20	2492
CLERICAL OFFICE EMPLOYEES NOC	8810	2902751.00	0.09	2612
BAR	9084	IF ANY	0.94	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	13106	0.020	262

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC. MO- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.20	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 005 FEIN 464250234 ENTITY CD 001 00 CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV MO- NO BUSINESS LOCATION				
CLERICAL OFFICE EMPLOYEES NOC	8810	395980.00	0.09	356

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	356	0.020	7

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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POLICY NUMBER: **UB-2L039306-20-14-G**

MO MANUAL PREMIUM $ 59135

WAIVER OF SUBROGATION	$ 1182
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	650
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	60967
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	59138
-25.00% SCHEDULE CREDIT(9887)	-14785
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	44353
-6.20% PREMIUM DISCOUNT(0064)	-2750
TERRORISM(9740)	406
TOTAL ESTIMATED PREMIUM	42009
5.00% MO SECOND INJURY FUND SURCHARGE	2100
TOTAL PREMIUM	44109
DEPOSIT AMOUNT DUE	44109

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **12432-MT**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 464250234 ENTITY CD 001 00				
CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV MT- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.31	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

MT MANUAL PREMIUM $ 0

WAIVER OF SUBROGATION	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	0
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-6.20% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
1.62% REGULATORY ASSESSMENT SURCHARGE	0
0.80% OSHA REGULATORY SURCHARGE	0
0.43% SUBSEQUENT INJURY FUND SURCHARGE	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-NC**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 464250234 ENTITY CD 001 00** **CRAFT BEER COMPANY** **SERVICES, NV** **MOORTGAT FINANCIAL** **DUVEL MOORTGAT, NV** **NC- NO BUSINESS LOCATION**				
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**186175.00**	**0.16**	**298**
CLASSIFICATION	**CODE**	**WAIVER PREMIUM BASIS**	**RATE**	**ESTIMATED ANNUAL PREMIUM**
BLANKET WAIVER OF SUBROGATION **SEE ENDT WC 00 03 13 00**	**0930**	**298**	**0.020**	**6**
CLASSIFICATION	**CODE**	**PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION**	**RATES PER $100 OF REMUNERATION**	**ESTIMATED ANNUAL PREMIUM**
LOCATION 002 **FEIN 811046925 ENTITY CD 005 00** **FIRESTONE WALKER, INC.** **5433 WADE PARK BLVD** **RALEIGH , NC 27607** **NAICS: 111199**				
SALESPERSONS OR COLLECTORS - OUTSIDE	**8742**	**300000.00**	**0.16**	**480**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION	0930	480	0.020	10
SEE ENDT WC 00 03 13 00				
BALANCE TO WAIVER MINIMUM PREMIUM	0930	84		

NC MANUAL PREMIUM $ 778

WAIVER OF SUBROGATION	$ 16
BALANCE TO WAIVER MINIMUM	84
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	8
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	886
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	860
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	860
-6.20% PREMIUM DISCOUNT(0064)	-53
TERRORISM(9740)	24
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	44
TOTAL ESTIMATED PREMIUM	875
TOTAL PREMIUM	875
DEPOSIT AMOUNT DUE	875

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **11347-NE**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY NE- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00 DUVEL MOORTGAT USA, LTD NE- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	62863.00	0.30	189

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	189	0.020	4

DATE OF ISSUE: **01-04-21 AW**

SCHEDULE NO: **1** OF **2**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

NE MANUAL PREMIUM $ 189

WAIVER OF SUBROGATION	$	4
1.10% EMPL. LIAB. INCREASED LIMITS(9812)		2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		195
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM		189
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		189
-6.20% PREMIUM DISCOUNT(0064)		-12
TERRORISM(9740)		3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		6
TOTAL ESTIMATED PREMIUM		186
TOTAL PREMIUM		186
DEPOSIT AMOUNT DUE		186

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13579-NJ**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
TAX IDENTIFIER NUMBER 463956867000				
BOULEVARD BREWING COMPANY				
106 KENNY PL				
SADDLE BROOK , NJ 07663				
NAICS: 111199				
FEIN 270038233 ENTITY CD 003 00				
TAX IDENTIFIER NUMBER 270038233000				
DUVEL MOORTGAT USA, LTD				
106 KENNY PL				
SADDLE BROOK , NJ 07663				
NAICS: 111199				
SALESPERSONS-OUTSIDE	8742	88425.00	0.42	371
LOCATION 002				
FEIN 811046925 ENTITY CD 005 00				
TAX IDENTIFIER NUMBER 811046925000				
FIRESTONE WALKER, INC.				
NJ- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	107000.00	0.42	449

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

NJ MANUAL PREMIUM $ 820

1.40% EMPL. LIAB. INCREASED LIMITS(6199)	$ 11
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	831
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	831
TERRORISM(9740)	59
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	20
TOTAL ESTIMATED PREMIUM	910
5.34% SECOND INJURY FUND SURCHARGE	44
TOTAL PREMIUM	954
DEPOSIT AMOUNT DUE	954

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-NM**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
100 W AVENIDA BERNALILLO BERNALILLO , NM 87004 NAICS: 111199				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	66000.00	0.28	185

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	185	0.020	4

NM MANUAL PREMIUM $ 185

WAIVER OF SUBROGATION	$ 4
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	191
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	185
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	185
-6.20% PREMIUM DISCOUNT(0064)	-11
TERRORISM(9740)	3
TOTAL ESTIMATED PREMIUM	177
TOTAL PREMIUM	177
DEPOSIT AMOUNT DUE	177

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13579-NV**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
NV- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	178000.00	0.60	1068

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	1068	0.020	21

NV MANUAL PREMIUM $ 1068

WAIVER OF SUBROGATION	$ 21
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	12
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	1101
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	1068
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1068
-6.20% PREMIUM DISCOUNT(0064)	-66
TERRORISM(9740)	78
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	20
DEPOSIT AMOUNT DUE	1100
TOTAL ESTIMATED PREMIUM	1100
TOTAL PREMIUM	1100

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15318-NY**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
656 COUNTY HIGHWAY 33 **COOPERSTOWN , NY 13326** **NAICS: 111199**				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
656 COUNTY HIGHWAY 33 **COOPERSTOWN , NY 13326** **NAICS: 111199**				
BREWERY & DRIVERS	**2121**	**IF ANY**	**4.58**	**0**
STORES: RETAIL STORE NOC-NO SERVICE OF FOOD	**8017**	**IF ANY**	**1.49**	**0**
SALESPERSONS-OUTSIDE	**8742**	**700394.00**	**0.30**	**2101**
CLERICAL OFFICE EMPLOYEES NOC	**8810**	**592565.00**	**0.12**	**711**
RESTAURANT-FULL SERVICE-INCLUDING ENTERTAINERS AND/OR MUSICIANS	**9071**	**IF ANY**	**1.82**	**0**

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION **SEE ENDT WC 00 03 13 00**	**0930**	**2812**	**0.020**	**56**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				

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

POLICY NUMBER: UB-2L039306-20-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 161499136 ENTITY CD 004 00				
BREWERY OMMEGANG, LTD.				
656 COUNTY HIGHWAY 33 COOPERSTOWN , NY 13326 NAICS: 111199				
BREWERY & DRIVERS	2121	1106209.00	4.58	50664
STORES: RETAIL STORE NOC-NO SERVICE OF FOOD	8017	156000.00	1.49	2324
CLERICAL OFFICE EMPLOYEES NOC	8810	63000.00	0.12	76
RESTAURANT-FULL SERVICE-INCLUDING ENTERTAINERS AND/OR MUSICIANS	9071	415000.00	1.82	7553

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	60617	0.020	1212

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003				
FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
NY- NO BUSINESS LOCATION				
SALESPERSONS-OUTSIDE	8742	338000.00	0.30	1014

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	1014	0.020	20

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

NY MANUAL PREMIUM $ 64443

WAIVER OF SUBROGATION	$	1288
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		65731
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM		63759
-5.00% SCHEDULE CREDIT(9887)		-3188
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		60571
-5.80% PREMIUM DISCOUNT(0063)		-3513
TERRORISM(9740)		1550
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		269
TOTAL ESTIMATED PREMIUM		58877
12.20% NY STATE ASSESSMENT		7612
TOTAL PREMIUM		66489
DEPOSIT AMOUNT DUE		66489

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13579-OH**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
OH- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.024	0

OH MANUAL PREMIUM $ 0

ADD FOR STOP GAP MINIMUM	$ 263
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	263
EXPERIENCE MODIFICATION: 0.97 MODIFIED PREMIUM	263
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	263
TOTAL ESTIMATED PREMIUM	263
TOTAL PREMIUM	263
DEPOSIT AMOUNT DUE	263

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-OK**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY OK- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00 DUVEL MOORTGAT USA, LTD OK- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	67306.00	0.28	188

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	188	0.020	4

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

OK MANUAL PREMIUM $ 188

WAIVER OF SUBROGATION	$ 4
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	195
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	189
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	189
-6.20% PREMIUM DISCOUNT(0064)	-12
TERRORISM(9740)	3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	7
TOTAL ESTIMATED PREMIUM	187
TOTAL PREMIUM	187
DEPOSIT AMOUNT DUE	187

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-OR**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
OR- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	366000.00	0.13	476

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	476	0.020	10

OR MANUAL PREMIUM $ 476

WAIVER OF SUBROGATION	$ 10
0.40% EMPL. LIAB. INCREASED LIMITS(9812)	2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	488
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	473
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	473
-10.80% PREMIUM DISCOUNT(0063)	-51
TERRORISM(9740)	37
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	37
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	496
8.40% WC PREMIUM ASSESSMENT	41
TOTAL PREMIUM	537
DEPOSIT AMOUNT DUE	537

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **12432-PA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
PA- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
PA- NO BUSINESS LOCATION				
SALESPERSON-OUTSIDE	0951	161907.00	0.17	275

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	275	0.020	6

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
PA- NO BUSINESS LOCATION				
SALESPERSON-OUTSIDE	0951	IF ANY	0.17	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

PA MANUAL PREMIUM $ 275

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 4
WAIVER OF SUBROGATION	6
0.950 MERIT MODIFICATION(9885)	-14
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	271
-6.20% PREMIUM DISCOUNT(0064)	-17
TERRORISM(9740)	32
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	16
TOTAL ESTIMATED PREMIUM	302
2.02% EMPLOYER ASSESSMENT	6
TOTAL PREMIUM	308
DEPOSIT AMOUNT DUE	308

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-RI**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 EMPLOYER IDENTIFIER 0002365162 BOULEVARD BREWING COMPANY RI- NO BUSINESS LOCATION				
FEIN 270038233 ENTITY CD 003 00 EMPLOYER IDENTIFIER 0002365162 DUVEL MOORTGAT USA, LTD RI- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	89780.00	0.21	189

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	189	0.020	4

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

RI MANUAL PREMIUM $ 189

WAIVER OF SUBROGATION	$	4
1.10% EMPL. LIAB. INCREASED LIMITS(9812)		2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		195
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM		189
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		189
-6.20% PREMIUM DISCOUNT(0064)		-12
TERRORISM(9740)		4
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		8
TOTAL ESTIMATED PREMIUM		189
TOTAL PREMIUM		189
DEPOSIT AMOUNT DUE		189

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: FARMINGTON CASUALTY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **22640-SD**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
SD- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	132374.00	0.28	371

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	371	0.020	7

SD MANUAL PREMIUM $ 371

WAIVER OF SUBROGATION	$ 7
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	382
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	371
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	371
-6.20% PREMIUM DISCOUNT(0064)	-23
TERRORISM(9740)	7
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	13
TOTAL ESTIMATED PREMIUM	368
DEPT OF LABOR SPEC POLICY FEE	14
TOTAL PREMIUM	382
DEPOSIT AMOUNT DUE	382

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **11347-TN**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 464250234 ENTITY CD 001 00 CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV TN- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	51268.00	0.19	97

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	97	0.020	2

TN MANUAL PREMIUM $ 97

WAIVER OF SUBROGATION	$ 2
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	100
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	97
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	97
-6.20% PREMIUM DISCOUNT(0064)	-6
TERRORISM(9740)	3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	6
TOTAL ESTIMATED PREMIUM	100
TOTAL PREMIUM	100
DEPOSIT AMOUNT DUE	100

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **15245-TX**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001				
FEIN 463956867 ENTITY CD 002 00				
BOULEVARD BREWING COMPANY				
401 TANGLEWOOD DR FRIENDSWOOD , TX 77546 NAICS: 111199				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				
401 TANGLEWOOD DR FRIENDSWOOD , TX 77546 NAICS: 111199				
SALESPERSONS, C M-OUTSIDE	8742	593101.00	0.07	415

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 42 03 04 B	0930	415	0.020	8

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 270038233 ENTITY CD 003 00 (CONT'D)				
11304 CHERISSE DR AUSTIN , TX 78739 NAICS: 111199				
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	0.07	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 42 03 04 B	0930	0	0.020	0

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003				
FEIN 270038233 ENTITY CD 003 00				
DUVEL MOORTGAT USA, LTD 5601 GASTON #204 DALLAS , TX 75215 NAICS: 111199				
SALESPERSONS, C M-OUTSIDE	8742	IF ANY	0.07	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 42 03 04 B	0930	0	0.020	0

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004				
FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC. TX- NO BUSINESS LOCATION				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 004 (CONT'D)				
SALESPERSONS, C M-OUTSIDE	8742	540000.00	0.07	378
CLASSIFICATION	**CODE**	**WAIVER PREMIUM BASIS**	**RATE**	**ESTIMATED ANNUAL PREMIUM**
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 42 03 04 B	0930	378	0.020	8

TX MANUAL PREMIUM $ 793

WAIVER OF SUBROGATION	$ 16
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	11
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	820
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	795
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	795
-11.90% PREMIUM DISCOUNT(0063)	-95
TERRORISM(9740)	90
TOTAL ESTIMATED PREMIUM	790
TOTAL PREMIUM	790
DEPOSIT AMOUNT DUE	790

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13579-UT**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
11718 S ROLLING CREEK WAY SOUTH JORDAN , UT 84095 NAICS: 111199				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	85000.00	0.21	179

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 43 03 05 00	0930	179	0.020	4

UT MANUAL PREMIUM $ 179

WAIVER OF SUBROGATION	$ 4
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	185
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	179
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	179
-6.20% PREMIUM DISCOUNT(0064)	-11
TERRORISM(9740)	6
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	13
TOTAL ESTIMATED PREMIUM	187
TOTAL PREMIUM	187
DEPOSIT AMOUNT DUE	187

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13439-VA**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 463956867 ENTITY CD 002 00 BOULEVARD BREWING COMPANY VA- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	66892.00	0.16	107

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	107	0.020	2

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 FEIN 811046925 ENTITY CD 005 00 FIRESTONE WALKER, INC.				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 002 (CONT'D)				
FEIN 811046925 ENTITY CD 005 00 (CONT'D)				
431 N 18TH ST RICHMOND , VA 23223 NAICS: 111199				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.16	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0

VA MANUAL PREMIUM $ 107

WAIVER OF SUBROGATION	$ 2
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	110
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	107
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	107
-6.20% PREMIUM DISCOUNT(0064)	-7
TERRORISM(9740)	20
TOTAL ESTIMATED PREMIUM	120
TOTAL PREMIUM	120
DEPOSIT AMOUNT DUE	120

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CRAFT BEER COMPANY **13579-WA**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 811046925 ENTITY CD 005 00				
FIRESTONE WALKER, INC.				
WA- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	167605.00	0.022	37

WA MANUAL PREMIUM $ 37

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 37
EXPERIENCE MODIFICATION: 0.97 MODIFIED PREMIUM	37
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	37
TOTAL ESTIMATED PREMIUM	37
TOTAL PREMIUM	37
DEPOSIT AMOUNT DUE	37

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: CRAFT BEER COMPANY **11223-WI**

RATE BUREAU ID: 911620235

EXP. MOD. EFFECTIVE DATE: 12-31-20

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 464250234 ENTITY CD 001 00 CRAFT BEER COMPANY SERVICES, NV MOORTGAT FINANCIAL DUVEL MOORTGAT, NV WI- NO BUSINESS LOCATION				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	0.47	0

CLASSIFICATION	CODE	WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
BLANKET WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00	0930	0	0.020	0
BALANCE TO WAIVER MINIMUM PREMIUM	0930	50		

WI MANUAL PREMIUM $ 0

WAIVER OF SUBROGATION	$ 0
BALANCE TO WAIVER MINIMUM	50
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	50
EXPERIENCE MODIFICATION:0.97 MODIFIED PREMIUM	48
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	48
-10.80% PREMIUM DISCOUNT(0063)	-5
EXPENSE CONSTANT(0900)	220
TOTAL ESTIMATED PREMIUM	263
TOTAL PREMIUM	263
DEPOSIT AMOUNT DUE	263

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-2L039306-20-14-G

LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 09 06 07 A - 001	FL WC INS GUARANTY ASSOC SURCH NOTIFIC
WC 24 04 06 D - 001	MISSOURI EMPLOYER PAID MEDICAL ENDT
WC 36 03 06 00 - 001	OREGON LIMITS OF LIABILITY
WC 36 06 02 OO - 001	OREGON CONFIDENTIALITY ENDORSEMENT
WC 36 06 04 00 - 001	OREGON AMENDATORY ENDORSEMENT
WC 99 06 U5 00 - 001	OHIO CANCELLATION AND NONRENEWAL ENDT
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 13 00 - 001	WAIVER OF OUR RIGHT TO RECOVER
WC 00 04 06 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 06 A - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 14 00 - 001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC 00 04 14 A - 001	NOTIFICATION OF CHG IN OWNR ENDT
WC 00 04 22 B - 001	TERRORISM RISK INS PROG REAUTH ACT ENDT
WC 00 04 22 B - 001	TERRORISM RISK INS PROG REAUTH ACT ENDT
WC 00 04 24 O0 - 001	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC 00 04 25 00 - 001	EXPER RATING MOD FACTOR REVISION ENDT
WC 04 03 01 B - 001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 09 04 03 B - 001	FL TRIPRA ENDORSEMENT
WC 32 03 01 D - 001	NORTH CAROLINA AMENDED COVERAGE ENDT
WC 35 03 03 00 - 001	OK EMP LIAB INTENTIONAL TORT EXCL ENDT
WC 99 03 76 A - 001	WAIVER OF OUR RIGHTS TO RECOVER-CA
WC 99 03 99 00 - 001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
WC 99 03 A1 00 - 001	NOTICE OF CANCELATION
WC 99 03 C3 00 - 001	SPECIAL PROVISIONS ENDT
WC 99 03 D3 A - 001	OHIO EMPLOYERS LIAB COVERAGE ENDT
WC 99 03 F3 00 - 001	CA LIMITS OF LIABILITY ENDT
WC 99 06 36 B - 001	CANCELLATION AMENDMENT - WASHINGTON
WC 99 06 R9 00 - 001	PENDING LAW CHANGE TO TRIPRA - NY

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-2L039306-20-14-G

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 04 21 D - 001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT
WC 99 04 08 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 99 01 19 B - 001	TRIPRA DISCLOSURE ENDORSEMENT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 02 04 01 C - 001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
WC 02 06 01 B - 001	AZ CANCELLATION AND NONRENEWAL ENDT
WC 03 06 01 B - 001	AR AMENDATORY ENDT
WC 04 03 05 00 - 001	VOL COMP & EMPLOYERS LIAB COV ENDT.
WC 04 03 17 B - 001	EMPLOYEE INSD BY GENERL EMPLYER EXCLUDED
WC 04 03 45 A - 001	COMPREHENSIVE PERSONAL LIAB POL EXCL
WC 04 03 60 B - 001	EMPLOYERS' LIAB COV AMENDATORY ENDT-CA
WC 04 04 21 00 - 001	OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
WC 04 04 22 00 - 001	CALIFORNIA SHORT-RATE CANCELATION ENDT
WC 04 06 01 A - 001	CA CANCELATION ENDT
WC 05 04 02 00 - 001	COLORADO CLASSIFICATION ENDORSEMENT
WC 06 03 01 00 - 001	CT APPLICATION OF WORKERS COMPENSATION
WC 06 03 03 C - 001	CONNECTICUT WC FUNDS ENDORSEMENT
WC 06 06 01 A - 001	CT NONRENEWAL AND RENEWAL ENDT
WC 08 06 01 00 - 001	DISTRICT OF COLUMBIA CANCELATION ENDT.
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 04 07 00 - 001	FL NON-COOPERATION WITH PREM AUDIT ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.
WC 10 06 01 C - 001	GA CANC NONRENEWAL AND CHANGE ENDT
WC 12 06 01 F - 001	IL AMENDATORY ENDT
WC 12 06 03 00 - 001	ILLINOIS RENEWAL ENDORSEMENT
WC 15 04 01 A - 001	KANSAS FINAL PREMIUM ENDORSEMENT
WC 15 06 01 A - 001	KANSAS CANCELATION AND NONRENEWAL ENDT.
WC 16 03 05 00 - 001	KY PART ONE WC INSURANCE ENDORSEMENT
WC 16 06 01 00 - 001	KY CANCELATION AND NONRENEWAL ENDT.
WC 16 06 02 00 - 001	KY NOTICE OF APPEAL RIGHTS ENDORSEMENT
WC 19 06 01 G - 001	MD CANCELLATION AND NONRENEWAL ENDT
WC 20 03 01 00 - 001	MA LIMITS OF LIABILITY ENDORSEMENT
WC 20 03 02 A - 001	MASSACHUSETTS - ASSESMENT CHARGE

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-2L039306-20-14-G

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 20 03 03 D - 001	MA NOTICE TO POLICYHOLDER ENDORSEMENT
WC 20 04 05 00 - 001	MASSACHUSETTS PREMIUM DUE DATE ENDT
WC 20 06 01 A - 001	MA CANCELLATION ENDORSEMENT
WC 22 00 00 A - 001	MN AMENDATORY ENDT
WC 22 03 01 00 - 001	MN COMPLIANCE WITH APPLICABLE TRADE LAW
WC 22 06 01 D - 001	MINNESOTA CANC AND NON RENEWAL ENDT
WC 24 03 02 00 - 001	MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT
WC 24 06 01 B - 001	MO CANCELATION AND NON-RENEWAL ENDT.
WC 24 06 02 B - 001	MO PROPERTY & CASUALTY GUARANTY ASSOC.
WC 24 06 04 C - 001	MISSOURI AMENDATORY ENDORSEMENT
WC 25 03 05 00 - 001	MT INTENTIONAL INJURY EXCLUSION
WC 25 06 01 B - 001	MONTANA AMENDATORY ENDORSEMENT
WC 25 06 02 00 - 001	MONTANA SAFETY ENDORSEMENT
WC 26 04 03 00 - 001	NE EXP RATING MOD FACTOR REV ENDT
WC 26 06 01 C - 001	NE CANCELATION ENDT
WC 27 06 01 C - 001	NV CANCELLATION AND NON RENEWAL ENDT
WC 29 03 06 B - 001	NJ PART TWO EMPLOYERS LIABILITY ENDT.
WC 30 03 01 00 - 001	NM SAFETY DEVICE COVERAGE ENDORSEMENT
WC 30 04 01 A - 001	NM WC PREM ADJ PROGRAM
WC 30 06 01 A - 001	NM CANCELLATION AND NONRENEWAL END
WC 31 03 08 00 - 001	NEW YORK LIMIT OF LIABILITY ENDORSEMENT
WC 31 03 19 J - 001	NY CONST CLASS PREM ADJUST PROG
WC 31 04 05 A - 001	NY SAFE PTNT HNDLG ACT PRGM ENDT FLAT CR
WC 31 06 18 A - 001	NEW YORK NOTICE OF RIGHT TO APPEAL
WC 35 06 01 F - 001	OK CANCELLATION NONRENEWAL & CHNG ENDT
WC 35 06 03 00 - 001	OK FRAUD WARNING ENDT
WC 36 04 06 00 - 001	OREGON PREMIUM DUE DATE
WC 36 06 01 E - 001	OR CANCELLATION ENDORSEMENT
WC 37 04 05 00 - 001	PA MERIT RATING PLAN ENDT
WC 37 06 01 00 - 001	SPECIAL PA ENDT - INSPECTION OF MANUALS
WC 37 06 02 00 - 001	NOTICE INS CONSULTATION SERVICE EXEMPT.
WC 37 06 03 A - 001	PA ACT 86-1986 ENDORSEMENT
WC 37 06 04 00 - 001	PA EMPLOYER ASSESSMENT ENDORSEMENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: **UB-2L039306-20-14-G**

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 38 04 01 B - 001	RI SHORT RATE CANCELLATION ENDORSEMENT
WC 38 06 01 00 - 001	RHODE ISLAND DIRECT LIABILITY STATUTE
WC 38 06 02 00 - 001	RI SAFETY INSPECTION ENDT
WC 40 06 01 A - 001	SOUTH DAKOTA DIRECT ACTION STATUTE ENDT
WC 40 06 03 00 - 001	SOUTH DAKOTA MANAGED CARE ENDORSEMENT
WC 40 06 05 B - 001	SD CANCEL & NON RENEWAL
WC 42 03 01 J - 001	TEXAS AMENDATORY ENDORSEMENT
WC 42 03 04 B - 001	TX WAIVER OF OUR RIGHT TO RECOVER
WC 42 04 07 00 - 001	TX AUDIT PREMIUM & RETRO PREM ENDT
WC 43 03 05 00 - 001	UTAH WAIVER OF SUBROGATION ENDORSEMENT
WC 43 06 01 00 - 001	UT WORKPLACE SAFETY PROG ENDT
WC 43 06 02 00 - 001	UTAH CANCELLATION ENDORSEMENT
WC 45 06 02 00 - 001	VA AMENDATORY ENDT
WC 48 06 01 C - 001	WISCONSIN LAW ENDORSEMENT
WC 48 06 06 B - 001	WISCONSIN CANCELLATION AND NON RENEWAL
WC 52 06 02 11 - 001	HAWAII NOTIFICATION ENDORSEMENT
WC 99 03 J9 00 - 001	KS WAIVER OF OUR RIGHT TO RECOVER
WC 99 06 46 00 - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 99 06 P5 00 - 001	WC AND EMPL LIAB INFO PAGE-OK AMEND ENDT
WC 99 06 S5 00 - 001	OR CLASSIFICATION CODE DESCRIPTION ENDT
W24N1A14 - 001	IMPORTANT NOTICE SCHEDULE-RATING-MO

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 06 07 (A)

POLICY NUMBER: UB-2L039306-20-14-G

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

This endorsement applies because Florida is shown in Item 3.A. of the Information Page.

Part Five – Premium, Section D. (Premium Payments) of the policy is revised by adding the following:

Florida statutes establish the Florida Workers' Compensation Insurance Guaranty Association Act.

On behalf of the Florida Workers' Compensation Insurance Guaranty Association (Association), we are required to bill and collect a surcharge for all workers compensation and employers liability insurance policies as prescribed by order of the Florida Office of Insurance Regulation.

The Association will use the funds collected through the surcharge to:

1. Pay for covered claims
2. Pay for reasonable costs to administer these covered claims
3. Avoid excessive delay in payment and to avoid financial loss to claimants because of the insolvency of a carrier

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

F. **Florida Workers' Compensation Insurance Guaranty Association Surcharge**

Failure to pay the Florida Workers' Compensation Insurance Guaranty Association surcharge will result in this policy being subject to pro rata cancellation in accordance with Part Six – Conditions, Section D.(Cancelation).

Schedule

Surcharge rate 1.00 %

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-04-21 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 04 06 (D)

POLICY NUMBER: UB-2L039306-20-14-G

MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT

This endorsement applies because Missouri is shown in Item 3.A. of the Information Page.

As a Missouri employer, you have the right, as provided by Section 287.957 of the Revised Statutes of Missouri, to have medical-only claims that do not exceed 20% of the current primary and excess loss split point amount, as shown in the Schedule below, excluded from your experience rating modification calculation. This will only be allowed when you pay all of the employee's medical costs; there is no lost time from the employment, other than the first three days or less of disability; and no claim is filed. The current primary and excess loss split point amount is provided in the rating values of NCCI's ***Experience Rating Plan Manual*****. You still must report all injuries, regardless of the dollar amount, to the Division of Workers' Compensation and to us.**

However, it should be noted that if, at any time, the medical expenses that are paid out-of-pocket due to a particular injury ever exceed 20% of the current primary and excess loss split point amount and/or the employee misses more than three days from work due to the injury, then this injury must be reported to us as a claim. We will pay the full amount of the claim, which includes any reimbursements due to you for past medical expenses incurred by you for this particular claim. As a result, the total amount of losses incurred by us due to this claim will be included in your experience modification calculation.

Schedule

20% of the Current Primary and Excess Loss Split Point Amount 3,500

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-04-21 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 03 (C)

POLICY NUMBER: UB-2L039306-20-14-G

EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

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

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

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

This insurance does not cover:

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

SCHEDULE

States

WA

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

ENDORSEMENT WC 00 03 11 (A) – 001

POLICY NUMBER: UB-2L039306-20-14-G

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

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	STATES WITH VOL COMP EXPOSURE EX CA NJ ND OH PR TX WA WI WY	STATE OF HIRE

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 13 (00) - 001

POLICY NUMBER: **UB-2L039306-20-14-G**

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.

Any person or organization for which the employer has agreed by written contract, executed prior to loss, may execute a waiver of subrogation. However, for purposes of work performed by the employer in Missouri, this waiver of subrogation does not apply to any construction group of classifications as designated by the waiver of right to recover from others (subrogation) rule in our manual.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 06 (A)

POLICY NUMBER: UB-2L039306-20-14-G

PREMIUM DISCOUNT ENDORSEMENT

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

SCHEDULE

1. State — **Estimated Eligible Premium**

	First	Next	Next	Balance
NJ MN TN	$10,000	$190,000	$1,550,000	

2. Average percentage discount: See Information Page Schedule(s)

3. Other policies:

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 22 (B)

POLICY NUMBER: UB-2L039306-20-14-G

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

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

Definitions

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

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.

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

a. The act is an act of terrorism.

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

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

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

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

"Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums , during the immediatel y preceding calendar year.

Limitation of Liability

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 22 (B)

POLICY NUMBER: UB-2L039306-20-14-G

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:

a. $100,000,000 with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.

b. $120,000,000 with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.

c. $140,000,000 with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.

d. $160,000,000 with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.

e. $180,000,000 with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.

f. $200,000,000 with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our insurer Deductible.

2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.

3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
AZ	0.01	
NC	0.005	
TX	0.008	

For all other states please refer to the other Federal Terrorism Risk Insurance Act Disclosure Endorsements attached to your policy

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-04-21 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 24 (O0)

POLICY NUMBER: UB-2L039306-20-14-G

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Part Five – Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge. The method for determining the Audit Noncompliance Charge by state, where applicable, is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5 – Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Note:

For coverage under state – approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
All states, except AK, CA, FL, IN, LA, MA, MO, MT, ND, NH, NY, OH, PA, TX, WA, WI, WY	Estimated annual premium	Multiplier varies based on number of consecutive policy periods in which you failed to comply with the Audit provision - First policy period: 25% - Second consecutive policy period: 50% - Third (or more) consecutive policy period(s): 75%

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-04-21 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 76 (A) - 001

POLICY NUMBER: UB-2L039306-20-14-G

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 2.00 % 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 Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-04-21 **ST ASSIGN:**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 C3 (00) –

POLICY NUMBER: UB-2L039306-20-14-G

SPECIAL PROVISIONS ENDORSEMENT STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

W24N1A14()-001	IMPORTANT NOTICE SCHEDULE-RATING-MO
APPLIES TO STATE(S):	
WC 00 03 03 (C)-001	EMPLOYERS LIAB COVERAGE ENDT
APPLIES TO STATE(S):	AR AZ CO CT DC GA HI IA ID IL IN KS KY MD MN MO MT NC NE NM NV NY OK OR PA RI SD TN TX UT VA WA WI
WC 00 03 11 (A)-001	VOLUNTARY COMP AND EMPLOYERS LIAB COV
APPLIES TO STATE(S):	AR AZ CO CT DC FL GA HI IA ID IL IN KS KY MA MD MN MO MT NC NE NM NV NY OK OR PA RI SD TN TX UT VA WI
WC 00 03 13 (00)-001	WAIVER OF OUR RIGHT TO RECOVER
APPLIES TO STATE(S):	AR AZ CO CT DC FL GA HI IA ID IL IN MA MD MN MO MT NC NE NM NV NY OK OR PA RI SD TN VA WI
WC 00 04 06 (A)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	MN NJ TN
WC 00 04 06 (00)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	AR CT GA IA KS KY MO NC NE NV TX VA
WC 00 04 14 (A)-001	NOTIFICATION OF CHG IN OWNR ENDT
APPLIES TO STATE(S):	AR AZ CO CT DC FL GA HI IA ID IL IN KS KY MD MN MO MT NE NM NV NY OK OR PA RI SD TN TX UT VA WI
WC 00 04 14 (00)-001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
APPLIES TO STATE(S):	MA
WC 00 04 19 (00)-001	PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S):	AR CO CT DC FL GA HI IA ID IL IN KS KY MD MN MO MT NC NE NJ NM NV NY OK PA RI SD TN UT VA WI
WC 00 04 21 (D)-001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT
APPLIES TO STATE(S):	AR AZ CA CO CT DC GA HI IA ID IL IN KS KY MD MT NC NE NJ NV NY OK OR PA RI SD TN UT WI
WC 00 04 22 (B)-001	TERRORISM RISK INS PROG REAUTH ACT ENDT
APPLIES TO STATE(S):	AR AZ CA CO CT DC GA HI IA ID IL IN KS KY MA MD MN MO MT NC NE NJ NM NV NY OK OR PA RI SD TN TX UT VA WI
WC 00 04 22 (B)-001	TERRORISM RISK INS PROG REAUTH ACT ENDT
APPLIES TO STATE(S):	AZ NC NJ TX WI
WC 00 04 24 (O0)-001	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
APPLIES TO STATE(S):	AR AZ CO CT DC GA HI IA ID IL IN KS KY MD NC NE NM NV OK OR RI SD TN UT VA WA
WC 00 04 25 (00)-001	EXPER RATING MOD FACTOR REVISION ENDT
APPLIES TO STATE(S):	AR AZ CO CT DC GA HI IA ID IL IN KS KY MA MD MN MO MT NC NE NJ NM NV NY OK OR PA RI SD TN TX UT VA WI
WC 02 04 01 (C)-001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
APPLIES TO STATE(S):	AZ
WC 02 06 01 (B)-001	AZ CANCELLATION AND NONRENEWAL ENDT

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S):	AZ
WC 03 06 01 (B)-001	AR AMENDATORY ENDT
APPLIES TO STATE(S):	AR
WC 04 03 01 (B)-001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
APPLIES TO STATE(S):	CA
WC 04 03 05 (00)-001	VOL COMP & EMPLOYERS LIAB COV ENDT.
APPLIES TO STATE(S):	CA
WC 04 03 17 (B)-001	EMPLOYEE INSD BY GENERL EMPLYER EXCLUDED
APPLIES TO STATE(S):	CA
WC 04 03 45 (A)-001	COMPREHENSIVE PERSONAL LIAB POL EXCL
APPLIES TO STATE(S):	CA
WC 04 03 60 (B)-001	EMPLOYERS' LIAB COV AMENDATORY ENDT-CA
APPLIES TO STATE(S):	CA
WC 04 04 21 (00)-001	OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
APPLIES TO STATE(S):	CA
WC 04 04 22 (00)-001	CALIFORNIA SHORT-RATE CANCELATION ENDT
APPLIES TO STATE(S):	CA
WC 04 06 01 (A)-001	CA CANCELATION ENDT
APPLIES TO STATE(S):	CA
WC 05 04 02 (00)-001	COLORADO CLASSIFICATION ENDORSEMENT
APPLIES TO STATE(S):	CO
WC 06 03 01 (00)-001	CT APPLICATION OF WORKERS COMPENSATION
APPLIES TO STATE(S):	CT
WC 06 03 03 (C)-001	CONNECTICUT WC FUNDS ENDORSEMENT
APPLIES TO STATE(S):	CT
WC 06 06 01 (A)-001	CT NONRENEWAL AND RENEWAL ENDT
APPLIES TO STATE(S):	CT
WC 08 06 01 (00)-001	DISTRICT OF COLUMBIA CANCELATION ENDT.
APPLIES TO STATE(S):	DC
WC 09 03 03 (00)-001	FL EMPLRS LIAB COVERAGE ENDT
APPLIES TO STATE(S):	FL
WC 09 04 03 (B)-001	FL TRIPRA ENDORSEMENT
APPLIES TO STATE(S):	FL
WC 09 04 07 (00)-001	FL NON-COOPERATION WITH PREM AUDIT ENDT
APPLIES TO STATE(S):	FL
WC 09 06 06 (00)-001	FL EMPLOYMENT AND WAGE INFORMATION REL.
APPLIES TO STATE(S):	FL
WC 09 06 07 (A)-001	FL WC INS GUARANTY ASSOC SURCH NOTIFIC
APPLIES TO STATE(S):	FL
WC 10 06 01 (C)-001	GA CANC NONRENEWAL AND CHANGE ENDT
APPLIES TO STATE(S):	GA
WC 12 06 01 (F)-001	IL AMENDATORY ENDT
APPLIES TO STATE(S):	IL
WC 12 06 03 (00)-001	ILLINOIS RENEWAL ENDORSEMENT
APPLIES TO STATE(S):	IL
WC 15 04 01 (A)-001	KANSAS FINAL PREMIUM ENDORSEMENT
APPLIES TO STATE(S):	KS

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 15 06 01 (A)-001 KANSAS CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): KS
WC 16 03 05 (00)-001 KY PART ONE WC INSURANCE ENDORSEMENT
APPLIES TO STATE(S): KY
WC 16 06 01 (00)-001 KY CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): KY
WC 16 06 02 (00)-001 KY NOTICE OF APPEAL RIGHTS ENDORSEMENT
APPLIES TO STATE(S): KY
WC 19 06 01 (G)-001 MD CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): MD
WC 20 03 01 (00)-001 MA LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 03 02 (A)-001 MASSACHUSETTS - ASSESMENT CHARGE
APPLIES TO STATE(S): MA
WC 20 03 03 (D)-001 MA NOTICE TO POLICYHOLDER ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 04 05 (00)-001 MASSACHUSETTS PREMIUM DUE DATE ENDT
APPLIES TO STATE(S): MA
WC 20 06 01 (A)-001 MA CANCELLATION ENDORSEMENT
APPLIES TO STATE(S): MA
WC 22 00 00 (A)-001 MN AMENDATORY ENDT
APPLIES TO STATE(S): MN
WC 22 03 01 (00)-001 MN COMPLIANCE WITH APPLICABLE TRADE LAW
APPLIES TO STATE(S): MN
WC 22 06 01 (D)-001 MINNESOTA CANC AND NON RENEWAL ENDT
APPLIES TO STATE(S): MN
WC 24 03 02 (00)-001 MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT
APPLIES TO STATE(S): MO
WC 24 04 06 (D)-001 MISSOURI EMPLOYER PAID MEDICAL ENDT
APPLIES TO STATE(S): MO
WC 24 06 01 (B)-001 MO CANCELATION AND NON-RENEWAL ENDT.
APPLIES TO STATE(S): MO
WC 24 06 02 (B)-001 MO PROPERTY & CASUALTY GUARANTY ASSOC.
APPLIES TO STATE(S): MO
WC 24 06 04 (C)-001 MISSOURI AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MO
WC 25 03 05 (00)-001 MT INTENTIONAL INJURY EXCLUSION
APPLIES TO STATE(S): MT
WC 25 06 01 (B)-001 MONTANA AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MT
WC 25 06 02 (00)-001 MONTANA SAFETY ENDORSEMENT
APPLIES TO STATE(S): MT
WC 26 04 03 (00)-001 NE EXP RATING MOD FACTOR REV ENDT
APPLIES TO STATE(S): NE
WC 26 06 01 (C)-001 NE CANCELATION ENDT
APPLIES TO STATE(S): NE
WC 27 06 01 (C)-001 NV CANCELLATION AND NON RENEWAL ENDT

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

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APPLIES TO STATE(S):  NV
WC 29 03 06 ( B)-001  NJ PART TWO EMPLOYERS LIABILITY ENDT.
APPLIES TO STATE(S):  NJ
WC 30 03 01 (00)-001  NM SAFETY DEVICE COVERAGE ENDORSEMENT
APPLIES TO STATE(S):  NM
WC 30 04 01 ( A)-001  NM WC PREM ADJ PROGRAM
APPLIES TO STATE(S):  NM
WC 30 06 01 ( A)-001  NM CANCELLATION AND NONRENEWAL END
APPLIES TO STATE(S):  NM
WC 31 03 08 (00)-001  NEW YORK LIMIT OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S):  NY
WC 31 03 19 ( J)-001  NY CONST CLASS PREM ADJUST PROG
APPLIES TO STATE(S):  NY
WC 31 04 05 ( A)-001  NY SAFE PTNT HNDLG ACT PRGM ENDT FLAT CR
APPLIES TO STATE(S):  NY
WC 31 06 18 ( A)-001  NEW YORK NOTICE OF RIGHT TO APPEAL
APPLIES TO STATE(S):  NY
WC 32 03 01 ( D)-001  NORTH CAROLINA AMENDED COVERAGE ENDT
APPLIES TO STATE(S):  NC
WC 35 03 03 (00)-001  OK EMP LIAB INTENTIONAL TORT EXCL ENDT
APPLIES TO STATE(S):  OK
WC 35 06 01 ( F)-001  OK CANCELLATION NONRENEWAL & CHNG ENDT
APPLIES TO STATE(S):  OK
WC 35 06 03 (00)-001  OK FRAUD WARNING ENDT
APPLIES TO STATE(S):  OK
WC 36 03 06 (00)-001  OREGON LIMITS OF LIABILITY
APPLIES TO STATE(S):  OR
WC 36 04 06 (00)-001  OREGON PREMIUM DUE DATE
APPLIES TO STATE(S):  OR
WC 36 06 01 ( E)-001  OR CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):  OR
WC 36 06 02 (OO)-001  OREGON CONFIDENTIALITY ENDORSEMENT
APPLIES TO STATE(S):  OR
WC 36 06 04 (00)-001  OREGON AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):  OR
WC 37 04 05 (00)-001  PA MERIT RATING PLAN ENDT
APPLIES TO STATE(S):  PA
WC 37 06 01 (00)-001  SPECIAL PA ENDT - INSPECTION OF MANUALS
APPLIES TO STATE(S):  PA
WC 37 06 02 (00)-001  NOTICE INS CONSULTATION SERVICE EXEMPT.
APPLIES TO STATE(S):  PA
WC 37 06 03 ( A)-001  PA 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 38 04 01 ( B)-001  RI SHORT RATE CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):  RI
```

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 38 06 01 (00)-001	RHODE ISLAND DIRECT LIABILITY STATUTE
APPLIES TO STATE(S):	RI
WC 38 06 02 (00)-001	RI SAFETY INSPECTION ENDT
APPLIES TO STATE(S):	RI
WC 40 06 01 (A)-001	SOUTH DAKOTA DIRECT ACTION STATUTE ENDT
APPLIES TO STATE(S):	SD
WC 40 06 03 (00)-001	SOUTH DAKOTA MANAGED CARE ENDORSEMENT
APPLIES TO STATE(S):	SD
WC 40 06 05 (B)-001	SD CANCEL & NON RENEWAL
APPLIES TO STATE(S):	SD
WC 42 03 01 (J)-001	TEXAS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	TX
WC 42 03 04 (B)-001	TX WAIVER OF OUR RIGHT TO RECOVER
APPLIES TO STATE(S):	TX
WC 42 04 07 (00)-001	TX AUDIT PREMIUM & RETRO PREM ENDT
APPLIES TO STATE(S):	TX
WC 43 03 05 (00)-001	UTAH WAIVER OF SUBROGATION ENDORSEMENT
APPLIES TO STATE(S):	UT
WC 43 06 01 (00)-001	UT WORKPLACE SAFETY PROG ENDT
APPLIES TO STATE(S):	UT
WC 43 06 02 (00)-001	UTAH CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):	UT
WC 45 06 02 (00)-001	VA AMENDATORY ENDT
APPLIES TO STATE(S):	VA
WC 48 06 01 (C)-001	WISCONSIN LAW ENDORSEMENT
APPLIES TO STATE(S):	WI
WC 48 06 06 (B)-001	WISCONSIN CANCELLATION AND NON RENEWAL
APPLIES TO STATE(S):	WI
WC 52 06 02 (11)-001	HAWAII NOTIFICATION ENDORSEMENT
APPLIES TO STATE(S):	HI
WC 99 01 19 (B)-001	TRIPRA DISCLOSURE ENDORSEMENT
APPLIES TO STATE(S):	OH WA
WC 99 03 76 (A)-001	WAIVER OF OUR RIGHTS TO RECOVER-CA
APPLIES TO STATE(S):	CA
WC 99 03 99 (00)-001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
APPLIES TO STATE(S):	CA
WC 99 03 A1 (00)-001	NOTICE OF CANCELATION
APPLIES TO STATE(S):	CO
WC 99 03 D3 (A)-001	OHIO EMPLOYERS LIAB COVERAGE ENDT
APPLIES TO STATE(S):	OH
WC 99 03 F3 (00)-001	CA LIMITS OF LIABILITY ENDT
APPLIES TO STATE(S):	CA
WC 99 03 J9 (00)-001	KS WAIVER OF OUR RIGHT TO RECOVER
APPLIES TO STATE(S):	KS
WC 99 04 08 (00)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	AR AZ CA CO CT DC FL GA HI IA ID IL IN KS KY MA MD MN MO MT NC NE NV NY OH OK OR PA RI SD UT VA WA WI
WC 99 06 36 (B)-001	CANCELLATION AMENDMENT - WASHINGTON

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-2L039306-20-14-G

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S):	WA
WC 99 06 46 (00)-001	ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	IL
WC 99 06 P5 (00)-001	WC AND EMPL LIAB INFO PAGE-OK AMEND ENDT
APPLIES TO STATE(S):	OK
WC 99 06 R9 (00)-001	PENDING LAW CHANGE TO TRIPRA - NY
APPLIES TO STATE(S):	NY
WC 99 06 S5 (00)-001	OR CLASSIFICATION CODE DESCRIPTION ENDT
APPLIES TO STATE(S):	OR
WC 99 06 U5 (00)-001	OHIO CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):	OH

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 04 08 (00)

POLICY NUMBER: **UB-2L039306-20-14-G**

PREMIUM DISCOUNT ENDORSEMENT

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

OTHER POLICIES:

DATE OF ISSUE: **01-04-21** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 04 03 05 (00) - 001

POLICY NUMBER: **UB-2L039306-20-14-G**

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: **01-04-21** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 42 03 04 (B) – 001

POLICY NUMBER: **UB-2L039306-20-14-G**

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.

1. ☐ Specific Waiver

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

2. Operations:

ALL TEXAS OPERATIONS

3. Premium:

The premium charge for this endorsement shall be **2.00** 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**

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by_____

DATE OF ISSUE: **01-04-21** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: **UB-2L039306-20-14-G**

UTAH WAIVER OF SUBROGATION ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Utah 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. (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 anyone not named in the Schedule. Our waiver of rights does not release your employees' rights against third parties and does not release our authority as trustee of claims against third parties.

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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 43 06 01 (00)

POLICY NUMBER: **UB-2L039306-20-14-G**

UTAH WORKPLACE SAFETY PROGRAM ENDORSEMENT

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

This endorsement is to inform you that you may be required to establish a workplace safety program and of the premium increase which will occur for failure or refusal to establish such a program.

You may be required to establish such a program if:

1. You have an experience modification factor of 1.00 or higher as determined by NCCI; or

2. You have a three year loss ratio of 100% or higher.

If you are required to implement a workplace safety program, the program must include a written accident and injury reduction plan and must be reviewed annually.

Your premiums may be increased by 5% over any existing rates and premium modifications for failure or refusal to establish a workplace safety program. If an increase has been made to your premium for failure or refusal to establish a workplace safety program, the amount of the increase is listed in the schedule below.

SCHEDULE

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 J9 (00) - 001

POLICY NUMBER: **UB-2L039306-20-14-G**

KANSAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Kansas 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. This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us, and

1. Such written contract is not a construction contract subject to the Kansas Fairness in Private Construction Contract Act (Kan. Stat. Sections 16-1801 through 16-1807) or the Kansas Fairness in Public Construction Contract Act (Kan. Stat. Sections 16-1901 through 16-1908), or any amendments to those laws; or

2. This policy is part of a consolidated or wrap-up insurance program.

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.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE **01-04-21** ST ASSIGN

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-2L039306-20-14-G

Oregon Classification Code Description Endorsement

This Endorsement applies to risks based in Oregon only.

Oregon Administrative Rule 836-043-0185 requires insurance carriers to provide Workers Compensation Classification descriptions when first issuing a Workers' Compensation policy to an insured with risks based in Oregon.

Listed in the schedule below are the detailed class code description(s) for the Oregon class codes on your policy. If you feel your operations are not adequately described by these descriptions please contact your agent.

Schedule

8742
Code 8742 is applied to outside salespersons or collectors. Since these employees are common to many businesses, they are considered to be Standard Exceptions. As such, they are classified to Code 8742 unless the classification applicable to their employment includes salespersons. Under the latter circumstance the outside salespersons or collectors are assigned to the classification that includes salespersons, not Code 8742.

Salespersons or collectors as defined in the Basic Manual are employees engaged in such duties away from the employers premises. Code 8742 is not available for employees who deliver merchandise. These employees are assigned to the drivers classification applicable to the risk even though these employees may also collect or sell. If they deliver merchandise by walking or using public transportation, they are assigned to the governing classification. Judgment is necessary in assessing these employees duties for classification purposes since occasional courtesy deliveries of a nominal quantity of merchandise would not preclude them from being classified to Code 8742

ACCOUNT NAME:
CRAFT BEER COMPANY
2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

POLICY NUMBER: **UB-2L039306-20-14-G**
EFFECTIVE DATE: **12-31-20**

IMPORTANT NOTICE – SCHEDULE RATING – MISSOURI

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

A schedule rating factor applies to your policy as follows:

Schedule Rating Criteria	**Schedule Rating Factor**
A. Premises – conditions, care (e.g., traffic areas kept clear and free of obstructions, adequate lighting) **Reasons/Basis:**	**+.00**
B. Return to Work Program (e.g., formal or informal program, workforce potential for Return to Work, transitional or light duty lists, designated responsible individual, injured worker progress tracking) **Reasons/Basis:**	**+.00**
C. Management Cooperation With Insurance Carrier (e.g., timely claim reporting, responsiveness to recommendations and/or Company requests for information) **Reasons/Basis:**	**+.00**

D. Safety Program
(e.g., written safety program, accident investigation, safety review and improvement process, use of Personal Protective Equipment required, designated safety coordinator)

Reasons/Basis:

RISK CONTROLMANAGEMENT IS VERY COMMITTED TO SAFETY -.15

E. Employee Selection, Training, Supervision
(e.g., skill level of workforce, drug testing, pre-employment physicals, annual turnover, training in safe work practicesand procedures, safety communications)

Reasons/Basis:

RISK CONTROL -LEVEL OF AUTOMATION IS GREATER THAN THEIR PEER S, LESS OF ACHANCE OF AMPUTIONS. -.10

F. Expense Reduction

Reasons/Basis:

+.00

Total Schedule Rating Factor -.25

IMPORTANT NOTICE – COPYRIGHT

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 RIGHTHS 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.

The National Council on Compensation Insurance and certain state workers compensation bureaus require a copyright notice on policy forms that contain their copyrighted material. This Important Notice addresses this copyright notice requirement for any policy form included in this policy that does not separately contain a copyright notice.

For all policy forms other than the workers compensation bureau forms of the states identified below:

Includes copyright material of the National Council on Compensation Insurance, Inc. used with its permission.
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For the workers compensation bureau policy forms of the following states:

DELAWARE:
© 2020 Delaware Compensation Rating Bureau

MICHIGAN:
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MINNESOTA:
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NEW JERSEY:
© Compensation Rating and Inspection Bureau

NEW YORK:
© 1987-2020 New York Compensation Insurance Rating Board

PENNSYLVANIA:
© 2020 Pennsylvania Compensation Rating Bureau

IMPORTANT NOTICE TO ARKANSAS POLICYHOLDERS

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.

Dear Policyholder:

In the event you need to contact someone about this policy for any reason, please contact your agent. If you need additional assistance you may contact us at the address and telephone number indicated below:

INSURANCE COMPANY

Travelers Property Casualty
One Tower Square
Hartford, CT 06183
1-800-842-9928

PRODUCER/AGENT

Name: LOCKTON COMPANIES LLC

Address: 444 W 47TH ST STE 900
KANSAS CITY MO 64112-1906

Phone Number: 816-960-9000

If you have been unable to contact or obtain satisfaction from the company or agent, you may contact the Arkansas Insurance Department:

Arkansas Insurance Department
One Commerce Way
Little Rock, Arkansas 72202
(501) 371-2640 or (800) 852-5494

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Department of Insurance, please have your policy number available.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at the address shown above.

Thank you for insuring with Travelers.

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION	P
Ark. Code. Ann. §11-9-403, 407 AWCC Rule 7 Updated 6-16-14	324 Spring Street, Little Rock, AR 72201 Mail: P.O. Box 950, Little Rock, AR 72203-0950 Little Rock Office – 1-800-622-4472 / 501-682-3930 Springdale Office – 1-800-852-5376 / 479-751-2790	

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS & EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

EMPLOYER—Name: CRAFT BEER COMPANY

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 660456
DALLAS, TX 75266-0456
Telephone No. (800) 238-6225
POLICY NUMBER: 2L039306 **EXPIRATION DATE:** 12-31-21

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by their employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. §11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and

(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and

(3) The alleged injury is later found to be a compensable injury; and

(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P

(Posting Notice)

A Posting Notice is mentioned in **Ark. Code Ann. §11-9-403, Ark. Code Ann. §11-9-407** and **AWCC Rule 7. AWCC Form P** satisfies all requirements.

Form P.

1. Is to be on display in a conspicuous place;
2. Tells employers what to do when an employee is injured.
3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;
4. Lists the claims office that will be handling the insurance aspects of the case;
5. Gives the claims office telephone number;
6. Announces the expiration date of the insurance policy; and
7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P.** Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about **FORM P** is available from the Support Services Division (1-800-622-4472 or 501-682-3930) .

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or concels any material information, or who willfully and knowingly employs any device, scheme, or actifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under … this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

ISSUE TO: **CRAFT BEER COMPANY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. W ithin one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date: **12-31-20** MPN Identification number **2493**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator **THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

You can also get free information from a State Division of W orkers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured W orkers."

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ISSUE TO: **CRAFT BEER COMPANY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. W ithin one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date: **12-31-20** MPN Identification number **2493**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator **THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

You can also get free information from a State Division of W orkers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured W orkers."

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ISSUE TO: **CRAFT BEER COMPANY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayora de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una ca da) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayora de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesi n, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médicaque proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir informaci n de su empleador si est cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede querirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN:

Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN: 12-31-20 Número de identificación de la MPN: **2493**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enferm edad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los lí mites establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensacón de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ISSUE TO: **CRAFT BEER COMPANY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayora de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesi n, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médicaque proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir informaci n de su empleador si est cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede querirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN:

Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN: 12-31-20 Número de identificación de la MPN: **2493**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enferm edad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los lí mites establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensacón de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

THE TRAVELERS INSURANCE COMPANIES

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303-318-8700 or toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17th Street, Suite 400, Denver, CO 80202-3626

Any information provided below comes from your employer and is specific to this place of employment:

NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission

Revised 10-01-2017

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

CRAFT BEER COMPANY
NO BUSINESS LOCATION
CT

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissoiner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 5008 **Telephone** (800) 238-6225

City/Town HARTFORD **State** CT **Zip Code** 06102-5008

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address 999 ASYLUM AVENUE **Telephone** (860) 566-4154

City/Town HARTFORD **State** CT **Zip Code** 06105

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you MUST file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name _____

Address _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TOP OST THIS NOTICE WILL SUBJECT THE EMLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted : _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the empolyer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

W06P1J17

ISSUED TO: **CRAFT BEER COMPANY** 2L039306

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injures and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including, an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

name/address/phone	name/address/phone	name/address/phone
name/address/phone	name/address/phone	name/address/phone

(Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers' Compensation Law is:

THE TRAVELERS INSURANCE COMPANIES
Name

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614 **(800) 238-6225**
address phone

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalities of up to $10,000.00 per violation (O.C.G. A. § 34-9-18 and § 34-9-19)

WC-P1 (7/2006)

W10P1P10

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañia opera bajo las Leyes de Compensacion de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, PREPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los limites de Ia ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 dias (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de Ia Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de Ia lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clinicas indústriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea Ia regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un tambio de un doctor a otro en Ia lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de Ia Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Corn pensación de Trabajadores
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
o 1-800-533-0682
http://www.sbwc.georgia.gov

nornbre /dirección /teléfono	nornbre /dirección /teléfono	nornbre /dirección /teléfono
nornbre /dirección /teléfono	nornbre /dirección /teléfono	nornbre /dirección /teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)
La cornpañia de seguro que provee cobertura para esta Ernpresa bajo Ia ley de Cornpensación de Trabajadores es:

THE TRAVELERS INSURANCE COMPANIES
Nombre

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614 **(800) 238-6225**
dirección teléfono

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: http://www.sbwc.georgia.gov

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER 0 NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G .A. § 34-9-18 § 34-9-19.)

WC-P1 (7/2006)

WORKERS' COMPENSATION

Is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.
2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims **THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT**			
Business address	**THE TRAVELERS INSURANCE COMPANIES** **P.O. BOX 660456** **DALLAS, TX 75266-0456**		
Business phone	**(800) 238-6225**		
Effective date	**12-31-20**	Termination date	**12-31-21**
Policy number	**UB-2L039306-20-14-G**	Employer's FEIN	**464250234**

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

W12P1O12

COMPENSACION A LOS TRABAJADORES

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

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

1. **OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los sintomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.
2. **NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
3. **CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

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

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

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

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

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Sordo): 312/814-2959

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

Nombre:	THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT		
Dirección de la Compañía:	THE TRAVELERS INSURANCE COMPANIES P.O. BOX 660456 DALLAS, TX 75266-0456		
Teléfono de la Compañía:	(800) 238-6225		
Fecha efectiva:	12-31-20	Fecha de terminación:	12-31-21
Número de Póliza:	UB-2L039306-20-14-G	FEIN del Empleador:	464250234

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

W12P2O12

Issued To: **CRAFT BEER COMPANY**

WORKERS' COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Workers' Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The Workers' Compensation insurance carrier or the administrator for

CRAFT BEER COMPANY

(name of company)

is: THE TRAVELERS INSURANCE COMPANIES

(name of insurance carrier or administrator)

(name of carrier/administrator)

P.O. BOX 660456

(mailing address)

DALLAS, TX 75266-0456

(city, state, zip)

(800) 238-6225

(telephone number)

WC Supervisor

(contact person)

For more information about rights or procedures under the Indiana Workers' Compensation system, call or write:

Workers' Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

Issued To: CRAFT BEER COMPANY

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

Cualquier empleado que sea lesionado mientras esté, trabajando debe reportar el accidente laboral inmediatamente a su supervisor, empleador o representante designado.

La compañía de seguro de compensación del trabajador o el administrador de la compañía

CRAFT BEER COMPANY

(nombre de la compañía)

es:

THE TRAVELERS INSURANCE COMPANIES

(nombre de la compañía de seguro/administrador)

P.O. BOX 660456

(dirección)

DALLAS, TX 75266-0456

(ciudad, estado, código postal)

(800) 238-6225

(número de teléfono)

WC Supervisor

(persona de contacto)

Para más información acerca de sus derechos o loss procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

Workers' Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

CRAFT BEER COMPANY

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

Workers Compensation Rights and Responsibilities

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

This notice applies to dates of accidents on or after April 25, 2013.
Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

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

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

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

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

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

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE.

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

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

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

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

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

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

THE TRAVELERS INSURANCE COMPANIES — ( ) (800) 238-6225

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 660456
DALLAS, TX 75266-0456

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
E-mail: KDOL.wc@ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

COMMONWEALTH OF KENTUCKY

WORKERS COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: CRAFT BEER COMPANY

Address: 2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

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

Policy #: UB-2L039306-20-14-G , effective 12-31-20 to 12-31-21

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

Telephone: (800) 238-6225 , Contact Person CLAIM MANAGER

EMPLOYEES: If INJURED - NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____ , phone number _____ .

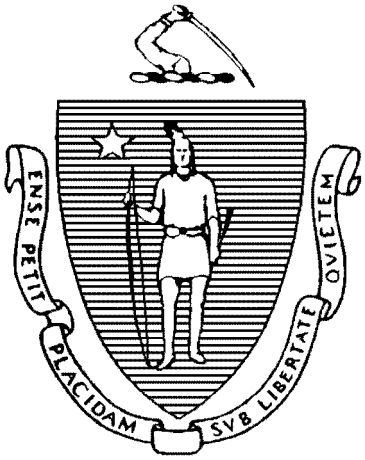
DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Department of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The Kentucky Department of Workers Claims at 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS - NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

W16P1P07

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts
DEPARTMENT OF INDUSTRIAL ACCIDENTS
LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111
(617) 727-4900 – www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above mentioned chapter by insuring with:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

P.O. BOX 4614
BUFFALO, NY 14240-4614

ADDRESS OF INSURANCE COMPANY

UB-2L039306-20-14-G **12-31-20** TO **12-31-21**

POLICY NUMBER EFFECTIVE DATES

LOCKTON COMPANIES LLC **444 W 47TH ST STE 900**
KANSAS CITY, MO 64112-1906

NAME OF INSURANCE AGENT ADDRESS PHONE #

CRAFT BEER COMPANY **NO BUSINESS LOCATION**
MA

EMPLOYER ADDRESS

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

W20P1G15

Workers' compensation

If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.

  The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.

  The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- **If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- **If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why they believe your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.

  If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 1-888-372-8366 to report workers' compensation fraud.

Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTMENT OF LABOR AND INDUSTRY

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Posting required by law in a location where employees can easily see this notice.

August 2017

Compensación laboral

Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podría perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada, (CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.

  La ley permite que la aseguradora de compensación laboral obtenga la información médica relacionada con su lesión sin su autorización, pero le debe enviar una notificación por escrito cuando solicite la información.

  La compañía aseguradora no puede obtener otros expedients médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación por escrito de su médico sobre cualquier autorización para ausentarse del trabajo. La nota debe ser lo más específica posible.

Compensación laboral paga por lo siguiente

- Atención médica para su lesión ocurrida en el trabajo, siempre que sea razonable y necesaria.
- Beneficios por salario perdido para cubrir parte de los ingresos no recibidos.
- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
- Servicios de rehabilitación vocacional si usted no puede regresar al trabajo o a su empleador previo al accidente debido a su lesión en el trabajo.
- Beneficios para su cónyuge o dependientes si usted fallece como consecuencia de una lesión laboral

Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a su reclamo por lesión.
- **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
- **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.

  Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con el teléfono gratuito para Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al 1-800-342-5354.**

Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Llame al 1-888-FRAUD MN (1-888-372-8366) para reportar fraude de compensación laboral.

Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTAMENTO DE TRABAJO E INDUSTRIA

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

W22P2H17

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self- Insured

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456, DALLAS, TX 75266-0456

Phone (800) 238-6225

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____, _____.
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relive the effects of the injury. This includes all costs for authorized medical treatment, prescription, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurance has the right to choose the healthcare provider or treating physician. you may select a different healthcare provided or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:

For Information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code reader app.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

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

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

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

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DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Aseguradora, administrador externo, Compañía de servicios o individuo designado si es autoasegurado

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son coma consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456, DALLAS, TX 75266-0456

Teléfono (800) 238-6225

Pasos a seguir si se lesiona en el trabajo

I. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

_____ , _____ .

representante del empleador *número de teléfono*

No hacerlo puede poner en peligro capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**

3. Obtenga más información de los beneifcios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita

Visite www.labor.mo.gov/DWC o llame al 800–775–2667.

Beneficios para trabajadores lesionados

Cuidados médicos:

El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enefrmedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:

Si un empleado muere en el trabajo. los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias toxicas – disparidad total permanente y/o muerte:

Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

** Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR .

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo. y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

I. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional,si es necesario.

2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.

3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derech o a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)

4. Para obtener más información sobre la responsabilidad o el seguro relacionadas con el Programa de compensación al trabajador, visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compaíñas de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri

Visite www.labor.mo.gov/MWSP o llame al 573- 751- 4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/ no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múlltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E. castigado con una multa de hasta S10,000, o el doble de la cantidad del fraude. lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para con seguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legitimo o quien deliberadamente hace una declaración de material fraudueInto o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A. castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación de los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri:711

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Beneficios para trabajadores lesionados

Cuidados médicos:

El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enefrmedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:

Si un empleado muere en el trabajo. los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias toxicas – disparidad total permanente y/o muerte:

Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

** Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR .

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo. y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

I. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional,si es necesario.

2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.

3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derech o a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)

4. Para obtener más información sobre la responsabilidad o el seguro relacionadas con el Programa de compensación al trabajador, visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compaíñas de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri

Visite www.labor.mo.gov/MWSP o llame al 573- 751- 4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/ no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múlltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E. castigado con una multa de hasta S10,000, o el doble de la cantidad del fraude. lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para con seguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legitimo o quien deliberadamente hace una declaración de material fraudueInto o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A. castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación de los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri:711

WORKERS' COMPENSATION
INSURANCE COVERAGE
EMPLOYEE NOTICE

CRAFT BEER COMPANY
2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

Date:
01-04-21
Policy Number:
UB-2L039306-20-14-G

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of **12-31-20 to 12-31-21** , provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 660456
DALLAS, TX 75266-0456
(800) 238-6225

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50 FINE AGAINST THE EMPLOYER!

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

TRAVELERS

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **Insurance Company**

for the period

Beginning 12-31-20 **Ending** 12-31-21

Employer CRAFT BEER COMPANY

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

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TRAVELERS

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Compañia de Seguro

por el periodo

Comenzando 12-31-20 **Terminando** 12-31-21

Patron CRAFT BEER COMPANY

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

TRAVELERS

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Compañia de Seguro

por el periodo

Comenzando 12-31-20 **Terminando** 12-31-21

Patron CRAFT BEER COMPANY

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) **Notice – In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form**
2) **You have the right to information and assistance from an information specialist known as an "Ombudsman" at the Workers' Compensation Administration.**
3) **Claims information – Contact your employer's Claims Representative.**

1) **Aviso. – En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.**
2) **Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.**
3) **Información acerca de Reclamaciones. – Contáctese con el representante de reclamaciones de su compañía.**

Employer's Insurer/Claims Representative:

Name: THE TRAVELERS INSURANCE COMPANIES

Phone #: (800) 238-6225

Address: P.O. BOX 660456 DALLAS, TX 75266-0456

Note: Employer must fill in this insurer/claims representative information.

WCA POSTER (TOP)
PART 1 OF 2
ATTACH BOTTOM OF
POSTER HERE

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por, escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Hobbs:	Las Cruces:	Las Vegas:	Roswell:	Santa Fe:
1-866-967-5667	**1-800-568-7310**	**1- 800-934-2450**	**1-800-870-6826**	**1-800-281-7889**	**1-866-311-8587**	**1-505-476-7381**
1-505-841-6000	**1-505-599-9746**	**1-575-397-3425**	**1-575-524-6246**	**1-505-454-9251**	**1-575-623-3997**	

If You Need HELP Call:
Ask for an Ombudsman
Si Usted Necesita Ayuda Llame Al:
Pregunte por un Ombudsman
1 – 8 6 6 – W O R K O M P (1-866-967-5667)
Visit our website at: https://workerscomp.nm.gov

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667
USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR
EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it.
This poster without Notice of Accident forms does not comply with law.
You have other rights and duties under the law.

New Mexico Workers' Compensation
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

11/18
W30P1K18

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

CRAFT BEER COMPANY

THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No **2L039306**
Policy in Force from **12-31-20** *to* **12-31-21**

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

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8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

CRAFT BEER COMPANY

THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No **2L039306**
Policy in Force from **12-31-20** *to* **12-31-21**

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Kenneth J. Munnelly, Chair

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form(Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).

2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)

3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.

4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.

5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.

6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.

7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)

8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.

9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.

10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.

11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

INSERT NAME AND ADDRESS OF INSURANCE CARRIER

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

KENNETH J. MUNNELLY
CHAIR

NYS Worker's Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

C-430S (9-16)
W31P5I16

ESTE RESUMEN ESTÁ ESCRITO EN ESPAÑOL AL DORSO

www.wcb.ny.gov

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

DECLARACION DE DERECHOS

JUNTA DE COMPENSACIONOBRERA
Kenneth J. Munnelly, Presidente

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).

2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)

3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.

4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.

5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.

6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.

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11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

INSERT NAME AND ADDRESS OF INSURANCE CARRIER

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

KENNETH J. MUNNELLY
PRESIDENTE

NYS Worker's Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

THIS NOTICE IS WRITTEN IN ENGLISH ON THE REVERSE SIDE.

C-430S (9-16)
W31P5I16

www.wcb.ny.gov

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Kenneth J. Munnelly, Chair

STATEMENT OF RIGHTS

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BUFFALO, NY 14240-4614

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C-430S (9-16)
W31P5I16

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www.wcb.ny.gov

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

DECLARACION DE DERECHOS

JUNTA DE COMPENSACIONOBRERA
Kenneth J. Munnelly, Presidente

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INSERT NAME AND ADDRESS OF INSURANCE CARRIER

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614

KENNETH J. MUNNELLY
PRESIDENTE

NYS Worker's Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

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C-430S (9-16)
W31P5I16

www.wcb.ny.gov

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER:
It is Important to Tell Your Employer about Your Injury

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: CRAFT BEER COMPANY **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:
TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

Telephone Number: (800) 238-6225

Insurer Code: 2148

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number:

IF SELF-INSURED:
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number:

Insurer Code:

IF SOMEONE OTHER THAN SELF-INSURER HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number:

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services	**Claims Information Services**	**Hearing Impaired**	**Email**
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

INSURED NAME: **CRAFT BEER COMPANY**

STATE OF RHODE ISLAND
DEPARTMENT OF LABOR & TRAINING

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company: **THE TRAVELERS INSURANCE COMPANIES**

Adjusting Company: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Telephone: **(800) 238-6225** Policy Effective Date: **12-31-20**

In accordance with Rhode Island General Law §28 -32-1, the **employer must report** to the Director of Labor and Training **every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed.
Fines may be imposed for noncompliance.

INSURED NAME: **CRAFT BEER COMPANY**

DEPARTAMENTO DE TRABAJO Y ENTRENAMIENTO DEL ESTADO DE RHODE ISLAND

Esta empresa esta sujeta a las estipulaciones del

ACTA DE COMPENSACION DE TRABAJADORES

del Estado de Rhode Island

Seguro de Compensación de Trabajo **THE TRAVELERS INSURANCE COMPANIES**

Compañía Ajustadora: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**

Teléfono: **(800) 238-6225** Fecha Efectiva de Póliza: **12-31-20**

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, **las empresas tienen que reportarle** al Director de Trabajo y Entrenamiento **cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad.** Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

Un empleado lesionado tiene la libertad de escoger al primer proveedor médico. La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atencíon inmediata, **no será considerado** el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.

WORKERS' COMPENSATION NOTICE THAT

Employer: CRAFT BEER COMPANY has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: THE TRAVELERS INSURANCE COMPANIES

Policy Number: UB-2L039306-20-14-G

Address for the above insurance carrier is P.O. BOX 173762 DENVER, CO 80217-3762

Telephone number is (800) 238-6225

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICALBILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury – no matter how slight – to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)
2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.
3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.
2. Ask your doctor to send a medical report to that insurance company.
3. Ask your employer to send a report of the accident to that insurance company
4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Lab or Commission at the above listed numbers or go to our web page at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

WORKERS' COMPENSATION NOTICE

Employer: CRAFT BEER COMPANY

has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: THE TRAVELERS INSURANCE COMPANIES

Policy Number: UB-2L039306-20-14-G

Address for the above insurance company: P.O. BOX 660456 DALLAS, TX 75266-0456

Telephone number: (800) 238-6225

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor **HOW, WHEN and WHERE** the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

UTAH
LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov.

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

COMPENSACIÓN AL TRABAJADOR
NOTE QUE

La empresa: CRAFT BEER COMPANY

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Titulo §34A-2-101, en el libro de Código de Utah anatado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensactión y otros beneficios preve idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: THE TRAVELERS INSURANCE COMPANIES

No. de Póliza: UB-2L039306-20-14-G

Dirección de la compañía de seguros: P.O. BOX 173762 DENVER, CO 80217-3762

Numero de teléfono: (800) 238-6225

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – su supervisor immediatamente. (Pierde sus derechos no reporta su accidente entre 180 dias después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compania de seguro dentro De los primeros siete (7) dias del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatemente para obtener tratamiento, Si no, vaya al doctor de su preferencia.
4. Digale al doctor **CÓMO, CUÁNDO Y DÓNDE** ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben se enviadas dentro de siete (7) dias de su visita a (1) la compañia de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah require lo siguiente que aparezca en esta forma, cualquier persona que intensionalmente presente información false o fraudulenta, que abara o cause que sea abierto un caso fraudulento de disabilidad o beneficios médicos, o que entregue un reporte fraudulento de factusas de gastos médicos u otros servicios profesionales es calpable de crimen y puede ser sujeto a multas y encarceuado en la prisión del Estada."

ESTADO DE UTAH

COMISION LABORAL

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensacion al Trabajador o si tiene pregunats, llame a la Comisión Labor a los números mencionados arriba o visite nuestra págnia de web en www.laborcommission.utah.gov.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Articulo §34A-2-204 ,and §34A-2-104.5 en el libro de Código de Utah anatado.

AVISO DE COMPENSACIÓN PARA LOS TRABAJADORES

La Empresa: CRAFT BEER COMPANY

Ha cumplido con las disposiciones de la Ley de Compensación para los Trabajadores (§34A-2-101, Código de Utah Anatado), la Ley de Enfermedades Ocupacionales de Utah (§34A-3-101, Código de Utah Anatado), y las reglas de la Comisión Laboral por asegurando la obligación de pagar compensactión y otros beneficios preveidos por las Leyes y teniendo cobertura con:

Compañía de Seguros: THE TRAVELERS INSURANCE COMPANIES

Numero de Póliza: UB-2L039306-20-14-G

Dirección de la compañía de seguros: P.O. BOX 660456 DALLAS, TX 75266-0456

Numero de teléfono: (800) 238-6225

☐ Marque aquí si la División de Accidentes Industriales ha autorizado el empleador a tener el auto-seguro y pagar los beneficios de compensación directamente al trabajador.

COMPENSACIÓN PARA LOS TRABAJADORES

Compensación para los trabajadores es un seguro que paga los gastos médicos y ayuda a compensar los salarios perdidos de los empleados con lesiones o enfermedades relacionadas con el trabajo. Si usted tiene una lesión en el trabajo o una enfermedad occupasional, puede pagar: facturas hospitalarias y médicas, pérdida de tiempo del trabajo, pérdida permanente de la función corporal, dispositivos protésicos y servicios funerarios y beneficios para dependientes en caso de muerte.

COMO REPORTAR UNACCIDENTE

1. Informe inmediatamente a su supervisor de la lesión. Usted puede perder sus derechos si no reporte su lesión o enfermedad relacionada con el trabajo dentro de 180 días.
2. Pregunte a su empleador dónde debe ir para recibir tratamiento. Si su empleador tiene un clínico designado, vaya allí de inmediato para recibir tratamiento. Si no tiene un clínico designado, vaya a un médico de su elección.
3. Informe al doctor **CÓMO, CUÁNDO y DÓNDE** ocurrió el accidente. El médico llenará el formulario de informe inicial del médico. Usted debe recibir una copia del informe y copias se envìan a la compañía de seguros y a la Comisión Laboral dentro de siete (7) días de su visita al médico.
4. Su empleador llenará el formulario de informe inicial del empleador. Usted debe recibir una copia del informe y una copia se envía a la compañía de seguros dentro de siete (7) días. La compañía de seguros es responsable a reportar a la Comisión Laboral.

COMO EMPEZAR COMPENSACIÓN

1. Pregunte a su empleador qué compañía de seguros pagará los beneficios de compensación para los trabajadores.
2. Pídale a su empleador que reporte el accidente a la compañía de seguros y que le dé el número de reclamo.
3. Llame a la compañía de seguros y pídales que inicien sus beneficios de compensación para trabajadores. La compañía de seguros requerirá el informe del empleador, el informe del médico, y puede pedirle a usted que llene una solicitud de compensación. Cooperar con la investigación del ajustador sobre la lesión.
4. Pídale a su médico que envíe informes médicos a la compañía de seguros, incluyendo la declaración de estado de trabajo.

REHABILITACIÓN

Si no puede regresar al trabajo, puede ser elegible para un programa de rehabilitación. Póngase en contacto con la compañía de seguros mencionada anteriormente o con la Oficina de Rehabilitación del Estado de Utah.

DECLARACIÓN DE FRAUDE: "Cualquier persona que a sabiendas presente información falsa o fraudulenta de suscripción de seguros, archivos o causas para presentar una reclamo falso o fraudulento por compensación de incapacidad o beneficios médicos, o presente un informe o facturación falsa o fraudulenta por gastos médicos u otros servicios profesionales es culpable de un crimen y pueden ser sujetos a multas y confinamiento en una prisión estatal."

UTAH
LABOR COMMISSION
Industrial Accidents Division

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Teléfono: (801)-530-6800 Fax: (801)-530-6804 LÌnea gratuita: (800)-530-5090 www.laborcommission.utah.gov

Si desea una copia del folleto de *la Guía Sobre el Seguro de Compensación Para los Trabajadores* o tiene preguntas, comuníquese con la Comisión Laboral o visite la página web en www.laborcommission.utah.gov.

Nota: Este aviso debe ser publicado y mantenido continuamente en lugares públicos y visibles en la oficina, tienda o lugar de negocios del empleador según §34A-2-204 y §34A-2-104.5, Código de Utah Anatado.

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 7-19)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

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

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

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

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

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3. percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi).

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5, 102(a)
EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456

DALLAS, TX 75266-0456

Contact Person _____

Phone (800) 238-6225 **Fax:** _____

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 7-19)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible**.

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

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

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

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

(2) **SIGA LAS INSTUCCIONES DE SU EMPLEADOR** para conseguir ayuda médica y siga las instrucciones del doctor.

(3) **BENEFICIOS MÉDICOS:** El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) **BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.

Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.

Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.1. Puede acceder a nuestro sitio web en http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi)

2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.

3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.

4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.

5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5, 102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456

DALLAS, TX 75266-0456

Persona de Contacto _____

Teléfono (800) 238-6225 Fax _____

Correo electrónico _____

NAMED INSURED: CRAFT BEER COMPANY

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

GUNTHER OPERATOR:

MANUALLY INSERT 2 COPIES OF THE ARIZONA OVERSIZED POSTING NOTICES

W02P2 – (ENGLISH)

W02P3 – (SPANISH)

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAME INSURED: CRAFT BEER COMPANY

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF THE COLORADO OVERSIZED POSTING NOTICE CP-5992 – YELLOW CARD STOCK

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAME INSURED: CRAFT BEER COMPANY

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF CP-6106

WASHINGTON D.C. OVERSIZED POSTING NOTICE

ATTACH WASHINGTON D.C. STICKERS

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: CRAFT BEER COMPANY

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF THE FLORIDA OVERSIZED POSTING NOTICES

W09P1 — (ENGLISH)

AND

W09P2 — (SPANISH)

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER–Name:	CRAFT BEER COMPANY
Address:	2501 SOUTHWEST BLVD
	KANSAS CITY MO 64108
CARRIER–Name:	THE TRAVELERS INSURANCE COMPANIES
Address:	VARIES BY LOCATION
AGENT–Name:	LOCKTON COMPANIES LLC
POLICY NUMBER:	UB-2L039306-20-14-G

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

CRAFT BEER COMPANY

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W19P1

MARYLAND OVERSIZED POSTING NOTICES

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER–Name: CRAFT BEER COMPANY
Address: 2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

Telephone No. (607) 376-6500 FEIN: 464250234

CARRIER–Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No. (800) 238-6225

POLICY NUMBER: 2L039306

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: CRAFT BEER COMPANY

POLICY NUMBER: UB-2L039306-20-14-G

EFFECTIVE DATE: 12-31-20

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W27P1

NEVADA OVERSIZED POSTING NOTICES

ATTACH NEVADA STICKERS

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

01-04-21

MANUAL INSERT INFORMATION

STICKER LABELS AND/OR POSTING NOTICES FOR MANUAL INSERT

FOR POLICY PRINTED IN JOB #: G154159B

Named Insured: CRAFT BEER COMPANY

Policy Number: UB-2L039306-20-14-G

Effective Date: 12-31-20

MANUAL INSERT INFORMATION

NAME OF INSURANCE COMPANY

THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD CT 06183

Policy Expiration Date: **12-31-2021**

NAME OF EMPLOYER

BY **CRAFT BEER COMPANY**

464250234

Employer ID Number

(If number unknown, employer to request from IRS)

D.C.

EMPLOYER – Name: CRAFT BEER COMPANY

Address: 2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 12-31-20

POLICY NUMBER: UB-2L039306-20-14-G Exp. Date: 12-31-21

EMPLOYER – Name: CRAFT BEER COMPANY

Address: 2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

AGENT – Name: LOCKTON COMPANIES LLC Eff. Date: 12-31-20

POLICY NUMBER: UB-2L039306-20-14-G Exp. Date: 12-31-21

EMPLOYER – Name: CRAFT BEER COMPANY

Address: 2501 SOUTHWEST BLVD
KANSAS CITY MO 64108

Telephone No: (607) 376-6500 FEIN: 464250234

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No: (800) 238-6225

POLICY NUMBER: 2L039306

ISSUED TO:	CRAFT BEER COMPANY
INSURER/ ADMINISTRATOR:	CLAIM MANAGER
CONTACT PERSON:	CLAIM MANAGER
Address:	P.O. BOX 71000 LAS VEGAS, NV 89170-1000
Telephone No.	(800) 238-6225

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY OVERPRINT PAGE

POLICY NUMBER: **UB-2L039306-20-14-G**

INSURED'S NAME: **CRAFT BEER COMPANY**

POLICY EFFECTIVE DATE: **12-31-20** POLICY EXPIRY DATE: **12-31-21**

NEW RENEWAL: **R** SUB-AGENT-CD: BILLING SYSTEM: **PABS**

PAYMENT PLAN: **MONTHLY** AUDIT FREQUENCY: **ANNUALLY**

SIC CODE: **2082** SAI: **1502D3193** PARENT FEIN: **464250234**

ALL OTHER GRAIN FARMING FI NEGOTIATED COMM: **0.07** AMS BINDER #:

POLICY PRICING PLAN: **GUARANTEED COST** PKG POL NBR:

POLICY PREDOMINANT COMPANY: **TIL** BUSINESS UNIT: **Commercial** NAICS: **111199**

STATE PREDOMINANT CLASS & PRICING PLAN:

ST	PRICING PLAN/DIV TABLE	COMPANY	ST PREDOM CLASS	ST	PRICING PLAN/DIV TABLE	COMPANY	ST PREDOM CLASS
AR	GUAR COST	AFC	8742	AZ	GUAR COST	ASF	8742
CA	GUAR COST	TIL	2121	CO	GUAR COST	ACJ	8742
CT	GUAR COST	ASF	8742	DC	GUAR COST	ASF	8742
FL	GUAR COST	TCT	8742	GA	GUAR COST	IND	8742
HI	GUAR COST	ASF	8742	IA	GUAR COST	TCT	8742
ID	GUAR COST	ACR	8742	IL	GUAR COST	TCT	8742
IN	GUAR COST	ASF	8742	KS	GUAR COST	AFC	8742
KY	GUAR COST	AFC	8742	MA	GUAR COST	TCT	8742
MD	GUAR COST	ASF	8742	MN	GUAR COST	ASF	8742
MO	GUAR COST	ACJ	2121	MT	GUAR COST	ACJ	8742
NC	GUAR COST	AFC	8742	NE	GUAR COST	IND	8742
NJ	GUAR COST	TIL	8742	NM	GUAR COST	AFC	8742
NV	GUAR COST	TIL	8742	NY	GUAR COST	COF	2121
OH	GUAR COST	TIL	8742	OK	GUAR COST	AFC	8742
OR	GUAR COST	AFC	8742	PA	GUAR COST	ACJ	0951
RI	GUAR COST	ASF	8742	SD	GUAR COST	AFC	8742
TN	GUAR COST	IND	8742	TX	GUAR COST	ASF	8742
UT	GUAR COST	TIL	8742	VA	GUAR COST	TIA	8742
WA	GUAR COST	TIL	8742	WI	GUAR COST	ACR	8742

OFFICE: **KANSAS CITY MO 095**

PRODUCER: **LOCKTON COMPANIES LL 54274** RATER: **AW**

ISSUE DATE: **01-04-21** CHANGE EFFECTIVE DATE: **12-31-20**

POLICY NUMBER: **UB-2L039306-20-14-G**

COMMISSION/INSTALLMENT SUMMARY

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
01-21	12/31/2020	94,544.00		.0700
01-21	12/31/2020	8.00	NJSIFS	.0000
01-21	12/31/2020	328.00	LECF	.0000
01-21	12/31/2020	330.00	CAOSHA	.0000
01-21	12/31/2020	411.00	CASIBFA	.0000
01-21	12/31/2020	118.00	CAUIEBF	.0000
01-21	12/31/2020	288.00	CAWCFA	.0000
01-21	12/31/2020	1,421.00	CAUFT	.0000
01-21	12/31/2020	6.00	PAASST	.0000
01-21	12/31/2020	219.00	MOWCSIFS	.0000
01-21	12/31/2020	5.00	MNSCF	.0000
01-21	12/31/2020	7.00	WCSUR	.0000
01-21	12/31/2020	5.00	SDSPF	.0000
01-21	12/31/2020	5.00	ORWCDA	.0000
01-21	12/31/2020	781.00	NYSA	.0000
01-21	12/31/2020	2.00	MAWCS	.0000
01-21	12/31/2020	10.00	ILICOFS	.0000
01-21	12/31/2020	7.00	FLWCIGA	.0000
TOTALS $	98,495.00			
01-21	01/31/2021	94,512.00		.0700
01-21	01/31/2021	4.00	NJSIFS	.0000
01-21	01/31/2021	315.00	LECF	.0000
01-21	01/31/2021	324.00	CAOSHA	.0000
01-21	01/31/2021	399.00	CASIBFA	.0000
01-21	01/31/2021	104.00	CAUIEBF	.0000
01-21	01/31/2021	277.00	CAWCFA	.0000
01-21	01/31/2021	1,414.00	CAUFT	.0000
01-21	01/31/2021	209.00	MOWCSIFS	.0000
01-21	01/31/2021	1.00	MNSCF	.0000
01-21	01/31/2021	1.00	SDSPF	.0000
01-21	01/31/2021	4.00	ORWCDA	.0000
01-21	01/31/2021	759.00	NYSA	.0000

POLICY NUMBER: **UB-2L039306-20-14-G**

COMMISSION/INSTALLMENT SUMMARY CONTINUED

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
TOTALS $	**98,323.00**			
02-21	02/28/2021	94,512.00		.0700
02-21	02/28/2021	4.00	NJSIFS	.0000
02-21	02/28/2021	315.00	LECF	.0000
02-21	02/28/2021	324.00	CAOSHA	.0000
02-21	02/28/2021	399.00	CASIBFA	.0000
02-21	02/28/2021	104.00	CAUIEBF	.0000
02-21	02/28/2021	277.00	CAWCFA	.0000
02-21	02/28/2021	1,414.00	CAUFT	.0000
02-21	02/28/2021	209.00	MOWCSIFS	.0000
02-21	02/28/2021	1.00	MNSCF	.0000
02-21	02/28/2021	1.00	SDSPF	.0000
02-21	02/28/2021	4.00	ORWCDA	.0000
02-21	02/28/2021	759.00	NYSA	.0000
TOTALS $	**98,323.00**			
03-21	03/31/2021	94,512.00		.0700
03-21	03/31/2021	4.00	NJSIFS	.0000
03-21	03/31/2021	315.00	LECF	.0000
03-21	03/31/2021	324.00	CAOSHA	.0000
03-21	03/31/2021	399.00	CASIBFA	.0000
03-21	03/31/2021	104.00	CAUIEBF	.0000
03-21	03/31/2021	277.00	CAWCFA	.0000
03-21	03/31/2021	1,414.00	CAUFT	.0000
03-21	03/31/2021	209.00	MOWCSIFS	.0000
03-21	03/31/2021	1.00	MNSCF	.0000
03-21	03/31/2021	1.00	SDSPF	.0000
03-21	03/31/2021	4.00	ORWCDA	.0000
03-21	03/31/2021	759.00	NYSA	.0000
TOTALS $	**98,323.00**			
04-21	04/30/2021	94,512.00		.0700
04-21	04/30/2021	4.00	NJSIFS	.0000

POLICY NUMBER: **UB-2L039306-20-14-G**

COMMISSION/INSTALLMENT SUMMARY CONTINUED

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
04-21	04/30/2021	315.00	LECF	.0000
04-21	04/30/2021	324.00	CAOSHA	.0000
04-21	04/30/2021	399.00	CASIBFA	.0000
04-21	04/30/2021	104.00	CAUIEBF	.0000
04-21	04/30/2021	277.00	CAWCFA	.0000
04-21	04/30/2021	1,414.00	CAUFT	.0000
04-21	04/30/2021	209.00	MOWCSIFS	.0000
04-21	04/30/2021	1.00	MNSCF	.0000
04-21	04/30/2021	1.00	SDSPF	.0000
04-21	04/30/2021	4.00	ORWCDA	.0000
04-21	04/30/2021	759.00	NYSA	.0000
TOTALS	$ 98,323.00			
05-21	05/31/2021	94,512.00		.0700
05-21	05/31/2021	4.00	NJSIFS	.0000
05-21	05/31/2021	315.00	LECF	.0000
05-21	05/31/2021	324.00	CAOSHA	.0000
05-21	05/31/2021	399.00	CASIBFA	.0000
05-21	05/31/2021	104.00	CAUIEBF	.0000
05-21	05/31/2021	277.00	CAWCFA	.0000
05-21	05/31/2021	1,414.00	CAUFT	.0000
05-21	05/31/2021	209.00	MOWCSIFS	.0000
05-21	05/31/2021	1.00	MNSCF	.0000
05-21	05/31/2021	1.00	SDSPF	.0000
05-21	05/31/2021	4.00	ORWCDA	.0000
05-21	05/31/2021	759.00	NYSA	.0000
TOTALS	$ 98,323.00			
06-21	06/30/2021	94,512.00		.0700
06-21	06/30/2021	4.00	NJSIFS	.0000
06-21	06/30/2021	315.00	LECF	.0000
06-21	06/30/2021	324.00	CAOSHA	.0000
06-21	06/30/2021	399.00	CASIBFA	.0000
06-21	06/30/2021	104.00	CAUIEBF	.0000
06-21	06/30/2021	277.00	CAWCFA	.0000

POLICY NUMBER: **UB-2L039306-20-14-G**

COMMISSION/INSTALLMENT SUMMARY CONTINUED

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
06-21	06/30/2021	1,414.00	CAUFT	.0000
06-21	06/30/2021	209.00	MOWCSIFS	.0000
06-21	06/30/2021	1.00	MNSCF	.0000
06-21	06/30/2021	1.00	SDSPF	.0000
06-21	06/30/2021	4.00	ORWCDA	.0000
06-21	06/30/2021	759.00	NYSA	.0000
TOTALS $	98,323.00			
07-21	07/31/2021	94,512.00		.0700
07-21	07/31/2021	4.00	NJSIFS	.0000
07-21	07/31/2021	315.00	LECF	.0000
07-21	07/31/2021	324.00	CAOSHA	.0000
07-21	07/31/2021	399.00	CASIBFA	.0000
07-21	07/31/2021	104.00	CAUIEBF	.0000
07-21	07/31/2021	277.00	CAWCFA	.0000
07-21	07/31/2021	1,414.00	CAUFT	.0000
07-21	07/31/2021	209.00	MOWCSIFS	.0000
07-21	07/31/2021	1.00	MNSCF	.0000
07-21	07/31/2021	1.00	SDSPF	.0000
07-21	07/31/2021	4.00	ORWCDA	.0000
07-21	07/31/2021	759.00	NYSA	.0000
TOTALS $	98,323.00			
08-21	08/31/2021	94,512.00		.0700
08-21	08/31/2021	4.00	NJSIFS	.0000
08-21	08/31/2021	315.00	LECF	.0000
08-21	08/31/2021	324.00	CAOSHA	.0000
08-21	08/31/2021	399.00	CASIBFA	.0000
08-21	08/31/2021	104.00	CAUIEBF	.0000
08-21	08/31/2021	277.00	CAWCFA	.0000
08-21	08/31/2021	1,414.00	CAUFT	.0000
08-21	08/31/2021	209.00	MOWCSIFS	.0000
08-21	08/31/2021	1.00	MNSCF	.0000
08-21	08/31/2021	1.00	SDSPF	.0000
08-21	08/31/2021	4.00	ORWCDA	.0000

POLICY NUMBER: **UB-2L039306-20-14-G**

COMMISSION/INSTALLMENT SUMMARY CONTINUED

ACCT MO	EFF DATE	GROSS AMT		COMM RATE
08-21	08/31/2021	759.00	NYSA	.0000
TOTALS	$ 98,323.00			
09-21	09/30/2021	94,512.00		.0700
09-21	09/30/2021	4.00	NJSIFS	.0000
09-21	09/30/2021	315.00	LECF	.0000
09-21	09/30/2021	324.00	CAOSHA	.0000
09-21	09/30/2021	399.00	CASIBFA	.0000
09-21	09/30/2021	104.00	CAUIEBF	.0000
09-21	09/30/2021	277.00	CAWCFA	.0000
09-21	09/30/2021	1,414.00	CAUFT	.0000
09-21	09/30/2021	209.00	MOWCSIFS	.0000
09-21	09/30/2021	1.00	MNSCF	.0000
09-21	09/30/2021	1.00	SDSPF	.0000
09-21	09/30/2021	4.00	ORWCDA	.0000
09-21	09/30/2021	759.00	NYSA	.0000
TOTALS	$ 98,323.00			

NJSIFS NJ SECOND INJURY FUND SURCHARGE
LECF CA LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT
CAOSHA CA OCCUPATIONAL SAFETY & HEALTH FUND ASSESSMENT
CASIBFA CA SUBSEQUENT INJURIES BENEFITS TRUST FUND ASSESS
CAUIEBF CA UNINSURED EMPLOYERS BENEFITS TRUST FUND ASSESS
CAWCFA CA STATE FRAUD SURCHARGE
CAUFT CA WC ADMINISTRATION REVOLVING FUND ASSESSMENT
PAASST PA EMPLOYER ASSESSMENT
MOWCSIFS MO SECOND INJURY FUND SURCHARGE
MNSCF MN SPECIAL COMPENSATION FUND ASSESSMENT
WCSUR DC WC POLICYHOLDER SURCHARGE
SDSPF SD DEPT OF LABOR SPEC POLICY FEE
ORWCDA OR WC PREMIUM ASSESSMENT
NYSA NY STATE ASSESSMENT
MAWCS MA DIA ASSESSMENT (PRIVATE)
ILICOFS IL WC COMMISSION OPERATIONS FUND SURCHARGE
FLWCIGA FL WC INS GRNTY ASSOC SRGHRG