Policy Number:	100 0001098
Named Insured:	WEYLCHEM US INC.
Agent:	Lockton Companies LLC 0005632

PULL POSTING NOTICE
FOR THE STATE OF:

NEW YORK

SOUTH CAROLINA

Starr Indemnity & Liability Co
399 Park Avenue
New York NY 10022-0000

WEYLCHEM US INC.
2114 LARRY JEFFERS ROAD
ELGIN SC 29045

Starr Indemnity
A Member of Starr Companies

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

Named Insured: **WEYLCHEM US INC.**

Effective Date: **01/01/2017**

Agency Name: **Lockton Companies LLC**

Welcome

Thank you for placing your Workers' Compensation coverage with Starr Indemnity & Liability.

Our Company

Starr Companies is a global insurance and financial services organization that provides innovative risk management solutions. We provide a range of property and casualty coverages as well as accident & health and specialty lines, including risks with international exposures. Our unparalleled leadership and unsurpassed expertise will help you succeed in an ever-changing world of risk. For more information, visit us at www.starrcompanies.com.

Our Mission is to consistently provide our clients with solutions in asset protection and risk management. We are dedicated to offering superior underwriting and loss control services. We respond to our client's needs in focused and innovative ways by developing products and services that will enable their growth and success.

We maintain a global focus and build on our international roots to enhance our presence in existing and emerging markets worldwide. We are committed to building long term relationships based on mutual trust and respect, and to providing services that will become the standard by which our competitors are judged.

Terms and Agreements

See your policy for Terms and Agreement information.

Starr Indemnity
A Member of Starr Companies

WORKERS COMPENSATION CLAIMS REPORTING

ALL Workers Compensation Claims, regardless of severity or location should be reported to the TPA immediately. The TPA Claims Intake Center is ready to accept new losses.

All claims must be reported by email, fax or by postal mail.

To expedite the handling of your claim, the following information must be provided when reporting a claim:

- **CLIENT /PROGRAM NAME:** WEYLCHEM US INC.
- **POLICY NUMBER:** 100 0001098
- **TPA NAME:** FARA INSURANCE SERVICES
- **TPA CLIENT CODE NUMBER:** 1008
- **TPA EMAIL:** StarrWCprogram@fara.com
- **TPA FAX NUMBER:** 877-297-3272
- **TPA MAILING ADDRESS:** ATTN: CLAIM OPENING
  1625 WEST CAUSEWAY APPROACH
  MANDEVILLE LA 70471

The TPA Claims Intake Center will review the notice upon receipt and assign the claim to the appropriate Branch Office. A claim acknowledgement letter will be transmitted to the designated individuals at the client's office advising of the TPA's claim number and the name and contact information of the adjuster assigned to the claim.

Starr Indemnity & Liability Company

Dallas, TX 1-866-519-2522

A Member of Starr Companies

KENTUCKY WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

Kentucky law requires that we provide a notice outlining the available deductibles for medical and/or indemnity expenses payable under your Workers Compensation and Employers Liability policy issued by Starr Indemnity & Liability Company. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced by the appropriate premium percentage. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your Kentucky operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place an "X" next to the deductible you want and return the signed, completed form to Starr Indemnity & Liability Company or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective the date we receive the form in our office.

	Deductible Amount
_____	$100
_____	$200
_____	$300
_____	$400
_____	$500
_____	$1,000
_____	$1,500
_____	$2,500
_____	$5,000
_____	$7,500
_____	$10,000

Signed: _____ Date: _____

Authorized Representative of Named Insured

Named Insured: WEYLCHEM US INC.

Named Insured's Mailing Address 2114 LARRY JEFFERS ROAD
ELGIN SC 29045

Policy Number: 100 0001098

Name and Address of Agent: Lockton Companies LLC
444 W 47th Street, Suite 900
Kansas City MO 64112

Starr Indemnity & Liability Company

Dallas, TX 1-866-519-2522

A Member of Starr Companies

Name & Mailing Address of the Insured:

WEYLCHEM US INC.
2114 LARRY JEFFERS ROAD
ELGIN SC 29045

Policy Number 100 0001098

Policy Period 01/01/2017 to 01/01/2018

Endorsement Number

WARNING
$ 500 FINE

Section 110 of the New York Workers' Compensation Law provides a penalty of up to $500 for an employer's failure to report injuries to employees promptly. In the event one of your employees is injured, to avoid any possibility of being subject to this $500 fine, report every claim promptly to the appropriate district office of the Workers' Compensation Board as shown on the back of the claim form.

Starr Indemnity & Liability Company

Dallas, TX 1-866-519-2522

A Member of Starr Companies

SOUTH CAROLINA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

South Carolina law requires that we provide a notice outlining the available deductibles for medical and/or indemnity expenses payable under your Workers Compensation and Employers Liability policy issued by Starr Indemnity & Liability Company. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced by the appropriate premium percentage. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your South Carolina operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place an "X" next to the deductible you want and return the signed, completed form to Starr Indemnity & Liability Company or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective the date we receive the form in our office.

	Deductible Amount
_____	$100
_____	$200
_____	$300
_____	$400
_____	$500
_____	$1,000
_____	$1,500
_____	$2,000
_____	$2,500

Signed: _____ Date: _____

Authorized Representative of Named Insured

Named Insured: WEYLCHEM US INC.

Named Insured's Mailing Address 2114 LARRY JEFFERS ROAD
ELGIN SC 29045

Policy Number: 100 0001098

Name and Address of Agent: Lockton Companies LLC
444 W 47th Street, Suite 900
Kansas City MO 64112

Starr Indemnity & Liability Company

Dallas, TX 1-866-519-2522

A Member of Starr Companies

TEXAS COMPLAINT NOTICE

Should any dispute arise about your premiums or about a claim that you have filed, contact the agent or write to the company that issued the policy. If the problem is not resolved, you may also write the State Board of Insurance, Department C, 1110 San Jacinto, Austin, Texas 78786. This notice of complaint procedure is for information only and does not become a part or condition of this policy.

TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE DISEASES AND ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

TO: Law Enforcement Officers, Fire Fighters, Emergency Medical Service Employees, Paramedics, and Correctional Officers -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, AN EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO A REPORTABLE DISEASE, INCLUDING HIV INFECTION, MUST BE TESTED FOR THE DISEASE NOT LATER THAN THE 10TH DAY AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A SWORN AFFIDAVIT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF THE DISEASE. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of Health. Exposure criteria and testing protocol must conform to Texas Department of Health requirements.

TO: All State Employees -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, A STATE EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, MUST BE TESTED FOR HIV WITHIN 10 DAYS AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A WRITTEN STATEMENT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF HIV INFECTION. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

FOR ADDITIONAL INFORMATION: TALK TO YOUR EMPLOYER OR CALL THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION AT 1-800-372-7713. ALSO, CONTACT THE TEXAS DEPARTMENT OF HEALTH (TDH) TO ENSURE FULL COMPLIANCE WITH THE HEALTH AND SAFETY CODE AND TDH RULES.

State of Connecticut Workers' Compensation Commission

Notice to Employees

Workers' Compensation Act

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

WEYLCHEM US INC.

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 commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such predjudice shall rest upon the employer." Such an injury report by the employee is NOT an official written notice of claim for workers' compensation benefits. (The Form 30C is necessary to satisfy this requirement.)

The INSURANCE COMPANY or SELF - INSURANCE ADMINISTRATOR Is:

Name STARR INDEMNITY & LIABILITY CO

Address 399 PARK AVENUE **Telephone** (646)227-6563

City/Town NEW YORK, NEW YORK **State** ___ **Zip Code** 10022

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

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

Address See Attached **Telephone** _____

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

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

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

Date Posted _____

Workers' Compensation Commission District Offices

District 1— Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 566-4154
Fax: (860) 566-6137

District 2— Norwich

90 Sachem Street
Norwich, CT 06360

Phone: (860) 823-3900
Fax: (860) 823-1725

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

Phone: (203) 789-7512
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

Phone: (203) 382-5600
Fax: (203) 335-8760

District 5— Waterbury

55 West Main Street
Waterbury, CT 06702

Phone: (203) 596-4207
Fax: (203) 596-4318

District 6— New Britain

233 Main Street
New Britain, CT 06051

Phone: (860) 827-7180
Fax: (860) 827-7913

District 7— Stamford

111 High Ridge Road
Stamford, CT 06905

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8— Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487

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	FARA INSURANCE SERVICES		
Business address	ATTN: CLAIM OPENING 1625 WEST CAUSEWAY APPROACH MANDEVILLE LA 70471		
Business phone	877-212-3272		
Effective date	01/01/2017	Termination date	01/01/2018
Policy number	100 0001098	Employer's FEIN	570485226

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

WC8145e (10-11) Wolters Kluwer Financial Services | Uniform Forms™

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 ultimo 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:	FARA INSURANCE SERVICES		
Dirección de la Compañía:	ATTN: CLAIM OPENING 1625 WEST CAUSEWAY APPROACH MANDEVILLE LA 70471		
Teléfono de la Compañía:	877-212-3272		
Fecha efectiva:	01/01/2017	Fecha de terminación:	01/01/2018
Número de Póliza:	100 0001098	FEIN del Empleador:	570485226

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

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: WEYLCHEM US INC.
Address: 2114 LARRY JEFFERS ROAD ELGIN SC 29045
Workers Compensation Carrier: FARA INSURANCE SERVICES
(or third party administrator):
Policy #: 100 0001098 **, effective** 01/01/2017 **to** 01/01/2018
ATTN: CLAIM OPENING 1625 WEST CAUSEWAY APPROACH
Address: MANDEVILLE LA 70471
Telephone: 877-212-3272 **, Contact Person:**

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 Client Support Representative , phone number (646)227-6400 .

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim 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.

04/09/09

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

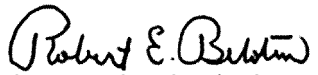
Customer Service Line: 877-632-4996

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 obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.



ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

For Insurance Carriers ONLY: Policy No 100 0001098

Policy in Force from 01/01/2017 *to* 01/01/2018

Name of employer (Nombre del patrono)
WEYLCHEM US INC.

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (1-11)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

FORM 17

Revised 11/2014

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

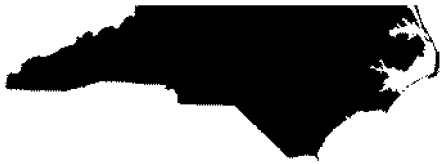
- **Report the injury or occupational disease to the Employer immediately.**
- **Give written notice to the Employer within 30 days.**
- **File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.**
- **If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/ administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.**
- **Your employer''s workers' compensation insurance carrier is** STARR INDEMNITY & LIABILITY CO.
- **The insurance policy number is** 100 0001098.
- **Your employer''s workers''compensation insurance policy is valid from** 01/01/2017 **until** 01/01/2018.

For assistance: Call the Industrial Commission HELP LINE--(800) 688-8349.

The Employer Should:

- **Provide all necessary medical services to the Employee.**
- **Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.**
- **Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.**
- **Ensure that compensation is promptly paid as required under the Workers' Compensation Act.**

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov



NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat.§ 97-93).

Forma 17 - Revisada 3/2004
PS-076

EMPLEADOR: ESTA INFORMACIÓN DEBE ESTAR PROMINENTEMENTE VISIBLE.
REGLA 201 DE LA COMISIÓN INDUSTRIAL

INFORMACIÓN SOBRE COMPENSACIÓN LABORAL
Instrucciones para Empleadores y Empleados

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, exepto oficiales ejecutivos expresamente excluidos.

— INFORMACIÓN IMPORTANTE EN CASO DE UNA LESIÓN O ENFERMEDAD OCUPACIONAL —

El empleado deberá:

1. Notificar inmediatamente por escrito al empleadore sobre la lesión o enfermedad ocupacional. El no informar al empleador dentro de los treinta (30) dias después de una lesión o desarrollo de una enfermedad ocupational, o el rehusar servicios médicos provistos por el empleador, pueden privar al empleado del derecho a compensación.

2. Hacer un reclamo a la Comisión Industrial (Industrial Commission) dentro de los dos (2) años de ocurrir el accidente o lesión, o dos (2) años después de la muerte, incapacidad o incapacitación causada por una enfermedad ocupacional. (Forma 18 de la Comisión puede ser utilizada para dar notificación al empleador y hacer el reclamo en la Comisión.) En caso de una lesión fatal, el reclamó deberá ser hecho por uno o más dependientes o herederos del empleado dentro de los dos (2) años después de la muerte del empleado

3. Si no se llega a un acuerdo con el empleador en relación al pago de compensación por lesión o enfermedad ocupacional, o si hay n desacuerdo en cuanto se debe de la compensación, el empleado lo mas pronto possible debe pedir una audiencia a la Comisión Industrial para que decian sobre los méritos del caso. Los beneficios pueden ser negados si la petición se hace después de dos (2) años de la fecha de la lesión o de el último pago de compensación.

El empleador debe:

1. Proveer todo servicio de hospital, médico, quirúrgico, y servicios de rehabilitación necesarios para la cura, el alivio y la minimización del período de incapacitación del empleado. N.C.G.S. §97-25. Mantener un archivo y reportar a la compañía de segurado/administrador de compensación TODAS las lesiones ocurridas a sus empleados usando la Forma 19 de la Comisión. El empleador, o el portador de seguro deben enviar por correo la Forma 19 a la Comisión Industrial dentro de los cinco (5) dias de ocurrido el reporte de una lesión que causa la ausencia del empleado por más de un (1) dia o $2,000.00 o más en tratamiento médico, excluyendo tratamientos provistos en el trabajo. N.C.G.S. §97-92.

2. Pagar compensación al empleado de acuerdo con lo provisto en el la Ley de Compensación Laboral para incapacidad. Los acuerdos de pago de compensación entre empleador y empleado deberán ser sometidos a la Comisión Industrial para su apruebo.

Información sobre alivio médico y monetario por lesiones ocurridas en el empleo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4340
(919) 807-2500

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: **WEYLCHEM US INC.**

Date Posted: _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:
STARR INDEMNITY & LIABILITY CO

Address: **NEW YORK, NEW YORK 10022**

399 PARK AVENUE

Telephone Number: **(646)227-6563**

Insurer's Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):
FARA INSURANCE SERVICES

Address: **ATTN: CLAIM OPENING**

1625 WEST CAUSEWAY APPROACH MANDEVILLE LA 70471

Telephone Number: **877-212-3272**

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 IS 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	toll-free inside PA TTY: 800.362.4228 local & outside PA TTY: 717.772.4991	ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

LIBC-500 REV 01-15

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: WEYLCHEM US INC. has workers' compensation insurance coverage from STARR INDEMNITY & LIABILITY CO. In the event of work-related injury or occupational disease. This coverage is effective from 01/01/2017. Any injuries or occupational diseases which occur on or after that date will be handled by STARR INDEMNITY & LIABILITY CO. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: **WEYLCHEM US INC.** **STARR INDEMNITY & LIABILITY CO** tiene cobertura de seguros de compensación para trabajadores con **STARR INDEMNITY & LIABILITY CO** para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde **01/01/2017** . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los equisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

(rev. 03/06)

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compensation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.

2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.

3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.

4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del aecidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.

2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.

3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, VA 23220
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE A VISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

(rev. 03/06)

PENNSYLVANIA POLICYHOLDER NOTICE
NOTICE OF ACCIDENT PREVENTION CONSULTING SERVICES
FOR THE STATE OF PENNSYLVANIA

As a Starr Indemnity & Liability Company workers' compensation policyholder we would like to inform you that loss prevention consulting services are available to your company.

Starr Indemnity & Liability Company's Loss Control unit can assist with your company's accident prevention process by providing a variety of loss control services, at no additional charge, that include the following types of service:

- Provision of on-site health and safety evaluation surveys, which identify all reasonable occupational safety and health hazards within the scope of the survey scheduled.

- Assistance with evaluating, obtaining, and maintaining personal protective equipment

- Evaluation of work practices, workplace design, and assistance with job site modifications.

- Assistance in evaluating and improving an employer's safety management practices.

- Assistance in developing and providing safety related training materials and/or programs.

- Information about the 5% premium discount available to employers who form a certified workplace safety committee.

If you would like to further discuss these services, please contact us at **1-855-656-6365** or write to:

Starr Indemnity & Liability Company
Attn: Loss Control
399 Park Avenue, 8th floor
New York, NY 10022

If you leave a message please include your name, phone number, company name, email address, workers compensation policy number and a brief decription of the loss control services being requested.

IMPORTANT NOTICE TO TEXAS POLICYHOLDERS

ACCIDENT PREVENTION SERVICES

Pursuant to Texas Labor Code §411.066, Starr Indemnity & Liability Company is required to notify its policyholders that accident prevention services are available from Starr Indemnity & Liability Company at no additional charge. These services may include:

- Surveys
- Recommendations
- Training Programs
- Consultations
- Analyses of Accident Causes
- Industrial Hygiene
- Industrial Health Services

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

If you would like more information, please contact Starr Indemnity & Liability Company at **1-855-656-6365** and LC.Staterequest@starrcompanies.com for accident prevention services or **1-855-827-5362** and Claims.StateRTW@starrcompanies.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000. If Starr Indemnity & Liability Company fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645;

PRIVACY POLICY AND PRACTICES

THIS NOTICE IS BEING SENT TO THE WORKERS' COMPENSATION PLAN PARTICIPANT (EMPLOYER). IT DESCRIBES THE POLICY OF STARR COMPANIES FOR HANDLING CERTAIN PERSONAL INFORMATION OF ITS INDIVIDUAL CUSTOMERS. THIS NOTICE IS PROVIDED TO THE EMPLOYER TO SATISFY STARR COMPANIES' NOTICE OBLIGATIONS UNDER STATE LAW.

Starr Companies collects certain personal information about you, which is described below in The Personal Information We Collect section. At Starr Companies, we respect the privacy of our customers. Our personal information handling practices are regulated by law, and this Privacy Policy describes those practices.

Starr Companies Privacy Policy

The Personal Information We Collect

Starr Companies collects personal information about you and the members of your household to conduct business operations, provide customer service, offer new products and satisfy legal and regulatory requirements.

We may collect the following categories of information about you from different sources. Examples include:**:**

- Information from you directly or through an agent, broker, your employer or other third parties such as insurance companies, government agencies, credit reporting agencies, courts or public records, including information from applications, worksheets, questionnaires, claim forms or other documents (such as name, address, telephone number and social security number)
- Information from other non-Starr Companies sources (such as prior loss information)
- Information from an employer, benefit plan sponsor, benefit plan administrator or master policyholder for any individual or group insurance product that you may have (such as name, address and social security number)

The Personal Information We Share

Starr Companies may disclose the personal information we collect to service, process, or administer business operations such as underwriting and claims, and for other purposes such as the marketing of products or services, regulatory compliance, the detection or prevention of fraud, or as otherwise required or allowed by law. These disclosures may be made without prior authorization from you, as permitted by law.

We may disclose such information about you to our affiliated companies and/or other third parties such as:

- Insurance companies;
- Insurance agencies;
- Third party administrators;
- Medical bill review companies;
- Reinsurance companies;
- Researchers;
- Business partners;
- Regulators;
- Law enforcement;
- Legal proceedings; and
- Public welfare.

When we use the term "personal information" we mean information that identifies you as an individual such as your name and social security number, your health information, as well as your financial and other information about you that is nonpublic.

You have a right to access and correct the personal information we collect, maintain and disclose about you.

Confidentiality and Security of Personal Information

Access to personal information is allowed for business purposes only. The people who have access to personal information, including employees of Starr Companies and its affiliates, and non-employees performing business functions for Starr Companies, are under obligations to safeguard such information. Starr Companies maintains physical, electronic, and procedural safeguards to guard your personal information.

Changes in Privacy Policy

Starr Companies may choose to modify this policy at any time. We will notify customers of any modifications at least annually.

How to Contact Us

You may obtain a more detailed description of the information practices prescribed by law by contacting us at the address below. Remember to include the following information: your name, address, policy number and daytime phone number.

Starr Companies Privacy Officer
399 Park Avenue
New York, New York 10022
(646) 227-6400

DEDUCTIBLE NOTICE OF ELECTION

Texas law permits an employer to obtain workers compensation insurance with a deductible. The insurance applies only to benefits payable under Texas workers compensation law. When a deductible is elected, the policyholder is required to reimburse the insurance carrier for benefits payable under the law up to the deductible amount and a credit is applied to the policy. Premium credits are determined based on the deductible selected and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

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

If a deductible amount is desired, please indicate below.

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

1. $_____ per accident

2. $_____ per claim

3. $_____ medical only

applied to benefits payable under the Texas Workers Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement _____
(monthly, quarterly or other)

☐ No, I do not want a deductible applied to benefits payable under the Texas Workers Compensation Law.

☐ Yes, I do want a deductible policy, but am unable to obtain one for the following reason:_____

_____

The deductible plans have been explained to me.

_____ _____
Signature and Title Date

_____ _____
Employer Name (print or type) Address

_____ _____ _____
Insurance Company Policy No. Effective Date

Starr Indemnity & Liability Company

A Member of Starr Companies

Dallas, TX 1-866-519-2522

IMPORTANT NOTICE TO POLICYHOLDERS

This Important Notice is not your policy. Please read your policy carefully to determine your rights, duties, and what is and what is not covered. Only the provisions of your policy determine the scope of your insurance protection.

THIS IMPORTANT NOTICE PROVIDES INFORMATION CONCERNING POSSIBLE IMPACT ON YOUR INSURANCE COVERAGE DUE TO COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS.

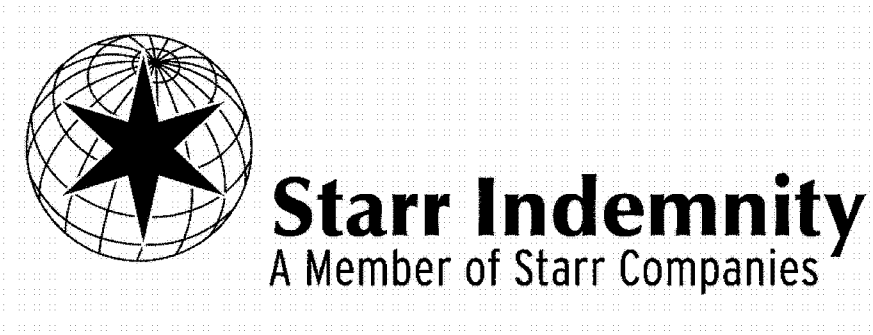
PLEASE READ THIS NOTICE CAREFULLY.

Various trade or economic sanctions and other laws or regulations prohibit us from providing insurance in certain circumstances. For example, the United States Treasury Department's Office of Foreign Asset Control (OFAC) administers and enforces economic and trade sanctions and places restrictions on transactions with foreign agents, front organizations, terrorists, terrorists organizations, and narcotic traffickers. OFAC acts pursuant to Executive Orders of the President of the United States and specific legislation, to impose controls on transactions and freeze foreign assets under United States jurisdiction. (To learn more about OFAC, please refer to the United States Treasury's web site at www.treas.gov)

To the extent that you or any other insured, or any person or entity claiming the benefits of this insurance has violated any applicable sanction laws, this insurance will not apply.

Charles H. Dangelo, President

Nehemiah E. Ginsburg, General Counsel



STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Starr Indemnity
A Member of Starr Companies

Workers Compensation and Employers Liability Insurance Policy

STARR INDEMNITY & LIABILITY CO
399 PARK AVENUE
NEW YORK, NEW YORK 10022

Policy Number	Policy Period From	To
100 0001098	01/01/2017	01/01/2018

12:01 A.M. Standard Time at the mailing address of the Insured as stated herein

Renewal Of	Transaction
100 0001098	Renewal Business

1. Named Insured and Mailing Address	Agent
WEYLCHEM US INC. 2114 LARRY JEFFERS ROAD ELGIN SC 29045	Lockton Companies LLC 444 W 47th Street, Suite 900 Kansas City MO 64112

UNEMPLOYMENT ID #	CARRIER #	FEIN #	Risk ID #	Entity of Insured
	11193	570485226	911956241	CORPORATION

Other Workplaces Not Shown Above: See attached Location Schedule

2. The Policy Period is from 01/01/2017 to 01/01/2018 12:01 a.m. Standard Time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: CT, IL, KY, NY, NC, PA, SC, TX, VA

B. Employers Liability Insurance: Part TWO of the policy applies to work in each state listed in Item 3A. 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: All states except North Dakota, Ohio, Washington, Wyoming, Puerto Rico and states designated in item 3. A. above. .

D. This policy includes these endorsements and schedules: See attached Endorsement Schedule

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

Assessments and Taxes **SEE EXTENSION OF INFORMATION PAGE**

Total Estimated Annual Premium	$	172,914
Expense Constant	$	280
Premium Discount	$ -	15,966
Deposit Premium	$	172,914

Minimum Premium $ 637

☐ This is a Three Year Fixed Rate Policy
Premium Adjustment Period: ☒ Annual; ☐ Semiannual; ☐ Quarterly; ☐ Monthly

Countersigned this Day of ,

Issued Date: 01/18/2017

Issuing Office

AUTHORIZED REPRESENTATIVE

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
CONNECTICUT					
UNIT: 00007 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	125,000	0.530000	$	663.00
	MANUAL PREMIUM			**$**	**663.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	663	0.011000	$	7.00
0930	WAIVER OF SUBROGATION	663	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	920	0.790000	$	-193.00
9889	SCHEDULED DEBIT	727	1.250000	$	182.00
0063	PREMIUM DISCOUNT	909	0.086000	$	-78.00
CM ASM	CT W/C FUND ASSESSMENT	909	1.018000	$	16.00
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	857	1.027500	$	24.00
9740	TERRORISM	125,000	0.010000	$	13.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	125,000	0.010000	$	13.00
	STATE TOTAL			**$**	**897.00**

EXTENSION OF INFORMATION PAGE

CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
ILLINOIS					
UNIT: 00006 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8810	CLERICAL OFFICE EMPLOYEES NOC	* IF ANY *	0.180000	$	0.00
	MANUAL PREMIUM			**$**	**0.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	0	0.014000	$	0.00
0930	WAIVER OF SUBROGATION	0	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	250	0.790000	$	-53.00
9889	SCHEDULED DEBIT	197	1.600000	$	118.00
0063	PREMIUM DISCOUNT	315	0.086000	$	-27.00
0900	EXPENSE CONSTANT			$	280.00
IICS	ILLINOIS INDUSTRIAL COMMISSION SURCHARGE	568	1.010100	$	6.00
9740	TERRORISM	0	0.050000	$	0.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	0	0.017000	$	0.00
	STATE TOTAL			**$**	**574.00**

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
KENTUCKY					
UNIT: 00008 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	230,000	0.390000	$	897.00
	MANUAL PREMIUM			**$**	**897.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	897	0.011000	$	10.00
9898	EXPERIENCE MODIFICATION	907	0.790000	$	-190.00
9889	SCHEDULED DEBIT	717	1.500000	$	359.00
0063	PREMIUM DISCOUNT	1,076	0.086000	$	-93.00
KY SRG	KENTUCKY WORKERS COMPENSATION SURCHARGE	1,057	1.062900	$	66.00
9740	TERRORISM	230,000	0.016000	$	37.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	230,000	0.016000	$	37.00
	STATE TOTAL			**$**	**1,123.00**

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NEW YORK					
UNIT: 00005 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8742	SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	* IF ANY *	0.490000	$	0.00
	MANUAL PREMIUM			**$**	**0.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	0	0.000000	$	0.00
0930	WAIVER OF SUBROGATION	0	1.000000	$	250.00
9898	EXPERIENCE MODIFICATION	250	0.790000	$	-53.00
9889	SCHEDULED DEBIT	197	1.050000	$	10.00
0063	PREMIUM DISCOUNT	207	0.086000	$	-18.00
9749	WC SECURITY FUND ASSESSMENT	179	1.000000	$	0.00
NY IDE	NY INSURANCE DEPARTMENT EXPENSE	197	1.000000	$	0.00
0932	NEW YORK STATE ASSESSMENT - ALL OTHER CLASSES	197	1.122000	$	24.00
9740	TERRORISM	0	0.061000	$	0.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	0	0.011000	$	0.00
	STATE TOTAL			**$**	**213.00**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NORTH CAROLINA					
UNIT: 00002 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	140,000	0.520000	$	728.00
	MANUAL PREMIUM			**$**	**728.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	728	0.011000	$	8.00
0930	WAIVER OF SUBROGATION	728	1.020000	$	100.00
9898	EXPERIENCE MODIFICATION	836	0.790000	$	-176.00
9889	SCHEDULED DEBIT	660	1.400000	$	264.00
0063	PREMIUM DISCOUNT	924	0.086000	$	-79.00
9740	TERRORISM	140,000	0.014000	$	20.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	140,000	0.014000	$	20.00
	STATE TOTAL			**$**	**885.00**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
PENNSYLVANIA					
UNIT: 00004 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
951	SALESPERSON OUTSIDE	90,000	0.470000	$	423.00
	MANUAL PREMIUM			**$**	**423.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	423	0.014000	$	6.00
0930	WAIVER OF SUBROGATION	423	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	679	0.950000	$	-34.00
9889	SCHEDULED DEBIT	645	1.250000	$	161.00
0063	PREMIUM DISCOUNT	806	0.086000	$	-69.00
0938	PENNSYLVANIA EMPLOYER ASSESSMENT	779	1.017000	$	13.00
9740	TERRORISM	90,000	0.031000	$	28.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	90,000	0.015000	$	14.00
	STATE TOTAL			**$**	**792.00**

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
SOUTH CAROLINA					
UNIT: 00001 ADDRESS: 2114 LARRY JEFFERS ROAD PERIOD: 01/01/2017 TO 01/01/2018					
4829	CHEMICAL MANUFACTURING NOC-ALL OPERATIONS & DRIVERS	7,910,000	2.200000	$	174,020.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	* IF ANY *	0.640000	$	0.00
8810	CLERICAL OFFICE EMPLOYEES NOC	1,300,000	0.260000	$	3,380.00
	MANUAL PREMIUM			**$**	**177,400.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	177,400	0.011000	$	1,951.00
0930	WAIVER OF SUBROGATION	177,400	1.020000	$	3,548.00
9898	EXPERIENCE MODIFICATION	182,899	0.790000	$	-38,409.00
9889	SCHEDULED DEBIT	144,490	1.250000	$	36,123.00
0063	PREMIUM DISCOUNT	180,613	0.086000	$	-15,533.00
9740	TERRORISM	9,210,000	0.014000	$	1,289.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	9,210,000	0.014000	$	1,289.00
	STATE TOTAL			**$**	**167,658.00**

EXTENSION OF INFORMATION PAGE

CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
TEXAS					
UNIT: 00003 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8810	CLERICAL OFFICE EMPLOYEES NOC	135,000	0.150000	$	203.00
	MANUAL PREMIUM			**$**	**203.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	203	0.014000	$	3.00
0930	WAIVER OF SUBROGATION	203	1.020000	$	4.00
9898	EXPERIENCE MODIFICATION	210	0.790000	$	-44.00
9889	SCHEDULED DEBIT	166	1.400000	$	66.00
0063	PREMIUM DISCOUNT	232	0.104000	$	-24.00
9740	TERRORISM	135,000	0.024000	$	32.00
	STATE TOTAL			**$**	**240.00**

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
VIRGINIA					
UNIT: 00009 ADDRESS: NFA					
PERIOD: 01/01/2017 TO 01/01/2018					
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	125,000	0.260000	$	325.00
	MANUAL PREMIUM			**$**	**325.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	325	0.011000	$	4.00
0930	WAIVER OF SUBROGATION	325	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	579	0.790000	$	-122.00
9889	SCHEDULED DEBIT	457	1.150000	$	69.00
0063	PREMIUM DISCOUNT	526	0.086000	$	-45.00
9740	TERRORISM	125,000	0.041000	$	51.00
	STATE TOTAL			**$**	**532.00**
	POLICY TOTAL			**$**	**172,914.00**

NAMED INSURED SCHEDULE

Loc Nbr	Loc Nbr
00001	

NAMED INSURED
NEASE CORPORATION
2114 LARRY JEFFERS ROAD
ELGIN SC 29045

FEIN: 570485226
UNEMPLOYMENT ID#

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00007	WEYLCHEM US INC. NFA NFA CT 29045
00008	WEYLCHEM US INC. NFA NFA KY 29045
00002	WEYLCHEM US INC. NFA NFA NC 51245
00001	WEYLCHEM US INC. 2114 LARRY JEFFERS ROAD ELGIN SC 29045
00009	WEYLCHEM US INC. NFA NFA VA 29045
00006	WEYLCHEM US INC. NFA NFA IL 29045
00005	WEYLCHEM US INC. NFA NFA NY 10004
00004	WEYLCHEM US INC. NFA NFA PA 11111
00003	WEYLCHEM US INC. NFA NFA TX 11111

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	WC000000C	1/15	WC & EL POLICY
CT	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
CT	WC000404	4/84	PENDING RATE CHANGE ENDT
CT	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
CT	WC000414	7/90	NOTIFICATION OF CHG IN OWNER
CT	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
CT	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CT	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CT	WC060301	4/84	CT APP OF WC INSURANCE ENDT
CT	WC060303B	4/96	CT WC FUNDS COVERAGE ENDT
CT	WC060601	1/03	CT NONRENEWAL ENDT
IL	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
IL	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
IL	WC000414	7/90	NOTIFICATION OF CHG IN OWNER
IL	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
IL	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
IL	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
IL	WC120601E	1/15	IL AMENDATORY ENDT
KY	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
KY	WC000414	7/90	NOTIFICATION OF CHG IN OWNER
KY	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
KY	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
KY	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
KY	WC160305	6/07	KY PART ONE W/C INS ENDT
KY	WC160601	12/97	KY CANCELATION/NONRENEWAL ENDT
KY	WC160602	10/99	KY NOTICE OF APPEAL RIGHTS
NY	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
NY	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
NY	WC000414	7/90	NOTIFICATION OF CHG IN OWNER
NY	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NY	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NY	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NY	WC310308	1/00	NY LIMIT OF LIABILITY ENDT
NY	WC310319H	10/16	NY CONSTR CLASS PREM ADJ PROG
NY	WC310618	3/15	NY NOTICE OF RIGHT TO APPEAL
NC	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
NC	WC000406A	7/95	PREMIUM DISCOUNT ENDT
NC	WC000414	7/90	NOTIFICAT OF CHNG IN OWNERS
NC	WC000419	1/01	PREMIUM DUE DATE ENDT
NC	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NC	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NC	WC320301C	1/14	AMENDED COV ENDT
PA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
PA	WC000404	4/84	PENDING RATE CHANGE ENDT
PA	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
PA	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
PA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
PA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
PA	WC370601	4/84	PA SPECIAL ENDT INSP MANUAL
PA	WC370602	4/84	PA NOTICE
PA	WC370603A	8/95	PA ACT 86-1986 ENDT
PA	WC370604	10/99	PA EMPLOYER ASSESSMENT ENDT
SC	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
SC	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
SC	WC000414	7/90	NOTIFICATION OF CHG IN OWNER
SC	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
SC	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
SC	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
TX	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
TX	WC000414	7/90	NOTIFICATION OF CHG IN OWNER

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
TX	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
TX	WC420301H	7/16	TX AMENDATORY ENDORSEMENT
TX	WC420304B	6/14	TX WAIVER OF RIGHT TO RECOVER
VA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
VA	WC000406	8/84	PREMIUM DISCOUNT ENDT
VA	WC000414	7/90	NOTIFICAT OF CHNG IN OWNERS
VA	WC000419	1/01	PREMIUM DUE DATE ENDT
VA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
VA	WC450602	7/93	AMENDATORY ENDT

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. **The Policy**

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

B. **Who is Insured**

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

C. **Workers Compensation Law**

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

D. **State**

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

E. **Locations**

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

PART ONE
WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

C. **We Will Defend**

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

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

D. **We Will Also Pay**

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

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

E. **Other Insurance**

We will not pay more than our share of benefits and costs covered by this insurance and other

insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. **Payments You Must Make**

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

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

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

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

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

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;

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

C. **Exclusions**

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651–1654), the Federal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901–944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. **We Will Defend**

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

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

E. **We Will Also Pay**

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

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

F. **Other Insurance**

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

G. **Limits of Liability**

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

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

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

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

H. **Recovery From Others**

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

I. **Actions Against Us**

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

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

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

PART THREE
OTHER STATES INSURANCE

A. **How This Insurance Applies**

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

B. **Notice**

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

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

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury claim,

proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. **Our Manuals**

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

B. **Classifications**

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

C. **Remuneration**

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

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

D. **Premium Payments**

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

E. **Final Premium**

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

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

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

F. **Records**

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

G. **Audit**

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

PART SIX - CONDITIONS

A. **Inspection**

We have the right, but are not obliged to inspect

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

B. **Long Term Policy**

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

C. **Transfer of Your Rights and Duties**

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

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

D. **Cancelation**

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

E. **Sole Representative**

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

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 anyone not named in the Schedule.

Schedule

Any person or organization to whom you become obligated to waive your rights of recovery against, under any contract or agreement you enter into prior to the occurrence of loss.

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: _____

PENDING RATE CHANGE ENDORSEMENT

A rate change filing is being considered by the proper regulatory authority. The filing may result in rates different from the rates shown on the policy. If it does, we will issue an endorsement to show the new rates and their effective date.

If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State
CONNECTICUT
PENNSYLVANIA

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: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

State	Estimated Eligible Premium			
	First	Next	Next	Balance
CONNECTICUT	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
KENTUCKY	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
NEW YORK	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
PENNSYLVANIA	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____ %

3. Other policies:

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

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: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

State	Estimated Eligible Premium First	Next	Next	Balance
SOUTH CAROLINA	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
TEXAS	$5,000	$95,000	$400,000	$500,000
	0.0%	9.5%	11.9%	12.4%
VIRGINIA	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____ %

3. Other policies:

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

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: _____

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 $10,000	Next $190,000	Next $1,550,000	Balance
ILLINOIS	0.0%	9.1%	11.3%	12.3%
NORTH CAROLINA	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

3. Other policies:

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

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: _____

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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

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: _____

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

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: _____

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
CONNECTICUT	0.010000	$13.00
ILLINOIS	0.017000	$0.00
KENTUCKY	0.016000	$37.00
NEW YORK	0.011000	$0.00
NORTH CAROLINA	0.014000	$20.00
PENNSYLVANIA	0.015000	$14.00
SOUTH CAROLINA	0.014000	$1,289.00

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: _____

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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

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

Definitions

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

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

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

a. The act is an act of terrorism.

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

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

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

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

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

Limitation of Liability

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

Policyholder Disclosure Notice

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

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

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

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

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

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

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

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

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

Schedule

State	Rate	Premium
CONNECTICUT	0.010000	$13.00
ILLINOIS	0.050000	$0.00
KENTUCKY	0.016000	$37.00
NEW YORK	0.061000	$0.00
NORTH CAROLINA	0.014000	$20.00
PENNSYLVANIA	0.031000	$28.00
SOUTH CAROLINA	0.014000	$1,289.00
TEXAS	0.024000	$32.00
VIRGINIA	0.041000	$51.00

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: _____

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

Section A, "How This Insurance Applies," of Part One, "Workers Compensation Insurance," is amended to read as follows:

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

1) Injury by accident must occur during the policy period.
2) Injury by disease must be caused or aggravated by exposure during the policy period to conditions of your employment.

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: _____

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 (Certificate of solvency; assessments; overpayments) of the Connecticut General Statutes. As provided in Section 31-284(c) (Employer rights and liabilities), we will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the law.

THE AMOUNT SHOWN ON THE INFORMATION PAGE FOR THE CONNECTICUT SECOND INJURY FUND SURCHARGE IS REQUIRED OF YOU UNDER CONNECTICUT REGULATIONS TO FINANCE THE CON NECTICUT SECOND INJURY FUND. WE WILL PAY THIS SURCHARGE TO THE CONNECTICUT STATE TREASURER.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT NONRENEWAL ENDORSEMENT

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

Add the following to **Part Six - Conditions** of the policy:

F. **Nonrenewal**

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you via registered mail, certified mail or by mail evidenced by a certificate of mailing, or deliver to the named insured at the address shown in the policy, at least sixty (60) days advance notice of our intention not to renew.

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

The notice of intent not to renew will state or be accompanied by a statement specifying the reason for such nonrenewal.

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: _____

ILLINOIS AMENDATORY ENDORSEMENT

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

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

3. For consequential bodily injury to a party to a civil union, spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

Part Five—Premium, Section G. (Audit) of the policy is replaced by the following:

G. Audit

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

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

A. Inspection

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

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

D. Cancellation

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

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

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

   a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;
   b. At least 60 days before the cancellation is to take effect if the policy has been in force for 61 days or more.

4. If this policy has been in effect for 60 days or more, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. The policy was issued because of a material misrepresentation;
   c. You violated any of the terms and conditions of the policy;
   d. The risk originally accepted has measurably increased;
   e. The Director has determined that we no longer have adequate reinsurance to meet our needs; or
   f. The Director has determined that continuation of coverage could place us in violation of the laws of Illinois.

5. Our notice of cancellation will state our reasons for cancelling.
6. The policy period will end on the day and hour stated in the cancellation notice.

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

E. Sole Representative

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

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

F. Nonrenewal

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

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

3. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. You notify us or the producer who procured this policy that you do not want the policy renewed; or
   b. You fail to pay all premiums when due; or
   c. You obtain other insurance as a replacement of the policy.

Note:

1. Cancellation and nonrenewal of the workers compensation and employers liability insurance policy is regulated by Sections 143.14, 143.15, 143.16, 143.16a, 143.17, and 143.17a of the insurance law of Illinois.
2. This endorsement must be attached to a policy showing Illinois in Item 3.A. of the Information Page.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE ENDORSEMENT

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

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

F. **Payments You Must Make**

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

Except for any payments for which we are responsible as provided in Section F.3. above, if we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

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

Nonrenewal

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

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

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: _____

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

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

NOTICE OF YOUR RIGHTS

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

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

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

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: _____

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

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

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

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: _____

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

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

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

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

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

Policy Effective Date	Third Quarter Payroll
4/1/14 thru 3/31/15	2013
4/1/15 thru 3/31/16	2014
4/1/16 thru 3/31/17	2015
4/1/17 thru 3/31/18	2016
4/1/18 thru 3/31/19	2017
4/1/19 thru 3/31/20	2018

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

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

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

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

NEW YORK WORKERS COMPENSATION
POLICYHOLDER NOTICE OF RIGHT TO APPEAL

Policyholder Disputes

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

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

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

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

Policyholder Right to Appeal

An insured, or its representative, (hereafter referred to as "insured"), may appeal the application of a rule or procedure contained in the NY Workers Compensation & Employers Liability Manual. Rules or procedures are defined as those determinations, either by a carrier or the Rating Board, which define the variables which makeup the policy conditions.

Examples include: classification codes, ownership information, premium audits, and any other determination which may affect the policy.

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

1. A staff member will review the request and respond to the insured within sixty (60) days, in writing, acknowledging receipt of the request, granting the insured its request or sustaining its original ruling.
2. The insured, if not satisfied with the outcome in 1. above, may then request, in writing, a conference with members of the Rating Board staff. The request must state the nature of the complaint and contain any supporting documents. The appropriate Department Vice President or his or her designated representative, if appropriate, will preside at the conference.
3. If the dispute is not resolved at the conference, the insured may then appeal to the Underwriting Committee of the Rating Board for a hearing to consider the staff ruling. This appeal must be in writing and must specify the reason(s) for the appeal and the nature of the complaint.

   Following, receipt of the appeal, the insured will be notified regarding the time and place for the hearing. The appeal will be heard at the next Underwriting Committee meeting for which appropriate time can be given for this matter. Subsequent to the hearing, the insured will be advised, in writing, of the Underwriting Committee decision regarding its complaint.
4. If the Underwriting Committee ruling is not satisfactory to the insured, the insured may then request a hearing at the New York State Department of Financial Services to consider the decision of the Rating Board's Underwriting Committee.
5. The New York State Department of Financial Services decision may be appealed to a higher court, by either the insured or the Rating Board

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

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

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

D. **Cancellation and Nonrenewal**

1. You may cancel this policy.

   If you cancel this policy, you must mail or deliver advance written notice to us stating when the cancellation is to take effect.

2. We may cancel this policy.

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

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

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

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

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

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

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

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

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

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

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

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

   (c) If we cancel for any of the reasons listed in paragraph (b), we must provide you with at least 15 days prior written notice of cancellation stating the precise reason for cancellation. We may provide this notice by registered or certified mail, return receipt requested, to you and any other person designated in the policy to receive notice of cancellation at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Whenever notice of cancellation is given by registered or certified mail, cancellation will not be effective unless and until that method is employed and completed. Notice of cancellation may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send notice as provided in this paragraph to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

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

3. We may refuse to renew this policy:

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

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

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

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

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

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SPECIAL PENNSYLVANIA ENDORSEMENT - INSPECTION OF MANUALS

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

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: _____

PENNSYLVANIA NOTICE

An Insurance Company, its agents, employees, or service contractors acting on its behalf, may provide services to reduce the likelihood of injury, death or loss. These services may include any of the following or related services incident to the application for, issuance, renewal or continuation of, a policy of insurance:

1. surveys;
2. consultation or advice; or
3. inspections.

The "Insurance Consultation Services Exemption Act" of Pennsylvania provides that the Insur ance Company, its agents, employees or service contractors acting on its behalf, is not liable for damages from injury, death or loss occurring as a result of any act or omission by any person in the furnishing of or the failure to furnish these services.

The Act does not apply:

1. if the injury, death or loss occurred during the actual performance of the services and was caused by the neg ligence of the Insurance Company, its agents, employees or service contractors;
2. to consultation services required to be performed under a written service contract not related to a policy of insurance; or
3. if any acts or omissions of the Insurance Company, its agents, employees or service contractor s are judicially determined to constitute a crime, actual malice, or gross negligence.

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: _____

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

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

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

Nonrenewal

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

Notice of Increase in Premium

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

Return of Unearned Premium

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

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: _____

PENNSYLVANIA EMPLOYER ASSESSMENT ENDORSEMENT

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

EMPLOYER ASSESSMENT FORMULA:

Employer Assessment	=	Act of 1997 Employer Assessment Factor	**X**	Employer Assessment Premium Base

Act 57 of 1997 Employer Assessment Factor

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

Employer Assessment Premium Base

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

CODE 0938

EMPLOYER ASSESSMENT FACTOR	**EMPLOYER ASSESSMENT**
1.017000	$ 13.00

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: _____

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

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

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

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

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

PART ONE - WORKERS COMPENSATION INSURANCE

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

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

F. **Payments You Must Make**

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

H. **Statutory Provisions**

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

PART TWO - EMPLOYERS' LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

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

Section 6 is amended to read:

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

D. **We Will Defend**

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

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

PART FIVE - PREMIUM

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

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

C. **Remuneration**

Number 2 is amended to read:

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

E. **Final Premium**

Number 2 is amended to read:

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

PART SIX - CONDITIONS

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

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

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

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

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

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

Add the following to the policy:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. **Claims Notification**

We are required to notify you of any claim that is filed against your policy. Thereafter we shall notify you of any proposal to settle a claim or, on receipt of a written request from you, of any administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Department of Insurance-Division of Workers' Compensation. You may, in writing, elect to waive this notification requirement.

We must, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE:

THE DISPUTE RESOLUTION PROCESS

THIS DISPUTE RESOLUTION PROCESS DOES NOT APPLY TO WORKERS COMPENSATION CLAIMS.

Proceed as follows if you have a dispute about your policy related to:

- Rates,
- The application or interpretation of rules contained in the various National Council on Compensation Insurance, Inc. (NCCI) manuals (including, but not limited to, classification codes and experience rating),
- Rating programs,
- Endorsements, or
- Forms.

First, contact the carrier that issued the policy and attempt to resolve the dispute directly. If the dispute is not directly esolved with the carrier, then contact NCCI, to ask for assistance through the dispute resolution process described in the Texas Miscellaneous Rules section of NCCI's Basic Manual. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and have paid undisputed premium that may be due to the carrier.

Send your request for assistance by mail to NCCI, Regulatory Assurance Department-Dispute Resolution Services, 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362; or by fax to 561-893-5043; or by email to regulatoryassurance@ncci.com.

NCCI will first work with you and the carrier to try to resolve the dispute. If you are unable to resolve the dispute to your satisfaction with NCCI's help, then you may ask NCCI to refer the dispute to the Texas Appeals Panel (Appeals Panel). The Appeals Panel consists of two insurance company representatives, an agent representative, a small employer, and a large employer, all appointed by the Texas Commissioner of Insurance. NCCI is the Administrator to the Texas Appeals Panel, and a staff member from TDI, appointed by the Commissioner, serves as the chair of the Panel.

Within 30 days of the date that the Appeals Panel issues a decision, any party to the dispute may appeal the decision to the Texas Department of Insurance. To appeal a decision of the Appeals Panel, contact the Texas Department of Insurance, Office of the Chief Clerk, Mail Code 113-2A, P.O. Box 149104, Austin, TX 78714-9104; or by fax to 512-490-1064; or by email to chiefclerk@tdi.texas.gov.

THIS NOTICE OF THE DISPUTE RESOLUTION PROCESS IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance-Division of Workers' Compensation, System Monitoring and Oversight, 7551 Metro Center Drive, Suite 100, MS-8, Austin, TX 78742; or by fax to 512-490-1030; or by e-mail to DWC-ComplaintResolution@tdi.texas.gov.

THIS NOTICE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

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

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

The premium for this endorsement is shown in the Schedule.

Schedule

1. ( ) Specific Waiver
   Name of person or organization

   (X) 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 2.0% 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 Extension Page

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

VIRGINIA AMENDATORY ENDORSEMENT

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

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

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

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: _____