

TEXAS
NOTICE OF ACCIDENT PREVENTION SERVICES

Pursuant to Texas Labor Code §411.066, Travelers is required to notify its policyholders that accident prevention services are available from Travelers at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. Travelers is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact Bill Belair at 214-570-6675 and wbelair@travelers.com for accident prevention services or 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 (512) 804-5000. If Travelers 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.

Notice To Policy Recipient:

If you are not the person directly responsible for the accident prevention activities for your company in Texas, please direct this notice of accident prevention services to the person directly responsible for accident prevention activities.

State of Texas

Important Loss Control Information

Texas Department of Insurance, Division of Workers' Compensation Rule 166.4(c)(2)(E) requires that workers' compensation insurance carriers solicit comments from each policyholder at least every 12 months, to determine the need for safety information or assistance. The attached Safety Services notice describes the services which are available to you at no additional charge, and where you may obtain them in the State of Texas.

If you need accident prevention assistance, have questions, or wish to bring an issue to our attention, phone us or write your comments below and either fax or mail this form to the Travelers Risk Control office listed below.

**FAX # (214) 570-6690
Phone # (214) 570-6682
Travelers
1301 E. Collins Blvd.
Richardson, TX 75081
Attn: Risk Control**

Comments

Policy # (if known):

Insured Name: _____

Address: _____

Phone & FAX Number:

Completed By: _____ **Title:** _____

Date: _____

SAFETY SERVICES

Notice to policy recipient: If you are not the person directly responsible for the accident prevention activities for your company, please direct this Safety Services notice to the person that is directly responsible for them.

SAFETY IS OUR CONCERN

Thank you for purchasing your insurance from one of the writing companies owned or managed by The Travelers Companies, Inc. We appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns safety and accident prevention. Travelers Risk Control department has the experience, resources and capabilities to provide a range of safety services, including site surveys, phone consultations, as well as provide access to numerous safety-related materials.

We have experience in a variety of industries, some of which include manufacturing, wholesale and retail businesses, service organizations, technology-related business, oil and gas-based business, and the public sector.

Following are some examples of available safety services:

Accident Prevention – Our staff can help you identify present and potential hazards in your operations, premises and equipment, and recommend measures for reducing or eliminating these hazards.

Analysis of Accident Causes – Although you investigate and keep records of accidents, we are available to assist if needed.

Safety Consultations – Our Consultants can help you with special problems such as ergonomics and human factors.

These services are available upon request. See the remainder of this document for the Travelers' Risk Control office nearest you. These phone numbers should not be used for questions regarding your policy or claims.

Industrial Hygiene/Health Services – We have the facilities and resources to answer your questions concerning job related industrial hygiene/health issues and to measure exposure to industrial hygiene hazards.

Safety Literature and Digital Media – We can provide you with top-notch safety-related literature, CDs, DVDs, and videos to assist in your loss control efforts. Also, we can direct you to several vendors who are able to provide additional safety materials, including brochures, pamphlets and digital media.

Safety Training – We offer face-to-face classroom courses, as well as distance learning programs that explore the risks our policyholders face and ways for them to control losses.

Return-To-Work Coordination – We can assist you with several aspects of the post injury management process.

Internet Website – Visit our Risk Control website for access to our safety newsletters and other safety literature at: <http://www.travelers.com/riskcontrol>

This website also has links to other safety-related Internet sites.

Please note: For ALL loss control assistance requests, please contact your local office directly, which is listed on one of the following pages.

SAFETY IS YOUR CONCERN

U.S. employers spend billions of dollars each year on the direct and indirect costs of work-related accidents. Dollar figures can't begin to reflect the pain and suffering of an injured worker and his or her family. But they do give some indication of the multiple consequences of a job-related accident... loss of time, interrupted production, damaged materials and equipment, the expense of retraining or replacing an injured worker, possible legal action from government regulatory agencies, and increased insurance costs.

It makes good sense for both employers and their employees to actively participate in a sound accident prevention program. The success of such a program depends to a large extent on your commitment to safety procedures and accident prevention techniques. Safety is a management concern. Maybe we can help.

You may want to consider the following **"Safety Checkpoints"** as you evaluate your organization's safety activities:

SELF-INSPECTION PROGRAM:

- Do you conduct periodic surveys of premises?... equipment?... operations?

SELF-INSPECTION PROGRAM (continued):

- Do you analyze each job to find inherent hazards?
- If you discover hazards, do you follow up with immediate corrective action?
- Do you monitor such action to make sure it is implemented and effective?

ACCIDENT INVESTIGATION:

- Do you investigate each accident?...determine the cause?
- Do you take immediate steps to prevent a recurrence?
- Do you keep records of accident investigations and follow-up measures?
- Do you complete accident statistics and analyze trends?

EDUCATION AND TRAINING:

- Do you take the time to train each of your employees to perform tasks safely?
- Do more-experienced employees receive training to correct bad habits that have developed over time?
- Do all employees understand that safety is an important part of their jobs?

Please call these numbers
FOR SAFETY SERVICES ONLY

For all other inquiries please contact your agent, underwriter or claim representative

ALABAMA

Birmingham

3000 Riverchase Galleria
Ste. 600
Birmingham, AL 35244
(678) 317-7708
Claims: 1-800-238-6214

ALASKA

Portland, OR

4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

ARIZONA

Phoenix

2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
(720) 200-8355

ARKANSAS

Richardson, TX

1301 E. Collins Blvd
Richardson, TX 75081
(214) 570-6675

CALIFORNIA

Diamond Bar

21688 Gateway Center Drive
P.O. Box 6512
Diamond Bar, CA 91765-8512
Risk Control: (714) 620-0682
Claims: (909) 612-3000

CALIFORNIA

Glendale

700 N. Central Avenue, 4th Floor
P.O. Box 1840
Glendale, CA 91209
Risk Control: (714) 620-0682
Claims: (909) 612-3000

CALIFORNIA

Los Angeles

888 South Figueroa St., Ste. 500
Los Angeles, CA 90017
(714) 620-0682
Risk Control: (714) 620-0682
Claims: (909) 612-3000

CALIFORNIA

Sacramento

11070 White Rock Road, Suite 130
Rancho Cordova, CA 95670
Risk Control: (916) 852-5245
Claims: (800) 727-3995

CALIFORNIA

San Diego

9325 Sky Park Court, Ste. 220
San Diego, CA 92123
(714) 612-0682

CALIFORNIA

Walnut Creek

225 Lennon Lane, Ste. 105
P.O. Box 8090
Walnut Creek, CA 94596-8090
Risk Control: (925) 945-4171
Claims: (800) 842-7354

COLORADO

Denver

6060 S. Willow Dr. #300
Greenwood Village, CO 80111
(720) 200-8355
Claims: 720-200-8100

CONNECTICUT

Hartford

300 Windsor Street
Hartford, CT 06120
(860) 954-3741
Claims: (860) 954-5190

DELAWARE

Washington, DC

10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
(215) 274-1610
Claims: 1-800-368-3562

DISTRICT OF COLUMBIA

Washington, DC

14200 Park Meadow Dr.
Chantilly, VA 20151
(571) 287-6232
Claims: 1-800-368-3562

FLORIDA

Orlando

2420 Lakemont Dr
Orlando, FL 32814
(407) 388-3307
Claims: 407-388-2400

GEORGIA

Atlanta

1000 Windward Concourse
Alpharetta, GA 30005
(678) 317-7708
Claims: 800-238-6214

HAWAII

Orange, CA

333 City Blvd. W
Suite 1100
Orange, CA 92868
(714) 620-0682

IDAHO

Portland, OR

4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

ILLINOIS

Chicago

200 North LaSalle Street
Suite 2200
Chicago, IL 60601
(630) 961-8074
Claims: 800-842-6172

ILLINOIS

Naperville

215 Shuman Boulevard
P.O. Box 3208
Naperville, IL 60566
(630) 961-8074
Claims: 800-842-6172

INDIANA

Indianapolis

Suite 300
6081 East 82nd Street
Indianapolis, IN 46250
(317) 845-1479
Claims: 800-238-6210

IOWA

Des Moines

7101 Vista Dr.
West Des Moines, IA 50266-9313
(651) 310-4422
Claims: 800-255-5072

KANSAS

Kansas City

7465 West 132nd
Overland Park, KS 66213
(913) 685-5109

KENTUCKY

Louisville

Suite 150
303 N Hurstbourne Pkwy
Louisville, KY 40222
(502) 429-7390
Claims: 800-238-6210

Please call these numbers
FOR SAFETY SERVICES ONLY

For all other inquiries please contact your agent, underwriter or claim representative

LOUISIANA

New Orleans

3838 N. Causeway, Suite 2700
Metairie, LA 70002
P.O. Box 61479
New Orleans, LA 70161-1479
(504) 832-7562
Claims: 800-842-2556

MAINE

Portland, ME

207 Larrabee Road, Suite 3
Westbrook, ME 04092
(207) 857-2021

MARYLAND

Washington, DC

14200 Park Meadow Dr.
Chantilly, VA 20151
(571) 287-6232
Claims: 1-800-368-3562

MASSACHUSETTS

Boston

100 Summer Street, Suite 201A
Boston, MA 02110
(781) 817-8370
Claims: 800-832-7839

MASSACHUSETTS

Hudson

1 Cabot Road
Suite 250
Hudson, MA 01749
(781) 817-8370
Claims: 800-832-7839

MASSACHUSETTS

Braintree

350 Granite Street
Suite 1201
Braintree, MA 02184
(781) 817-8370
Claims: 800-832-7839

MICHIGAN

Grand Rapids

3777 Sparks Ave. SE, Ste. 200
P.O. Box 3010
Grand Rapids, MI 49501-0323
(248) 312-7301
Claims: 800-238-6210

MICHIGAN

Troy

1301 W. Long Lake Rd., Ste. 300
Troy, MI 48098
(248) 312-7301
Claims: 800-238-6210

MINNESOTA

St. Paul

385 Washington St., MC 104P
St. Paul, MN 55102
(651) 310-4422
Claims: 800-842-3073

MISSISSIPPI

Jackson

1080 River Oaks Dr
Ste B-200
Flowood, MS 39232
(601) 936-8212
Claims: 1-800-342-4064

MISSOURI

Maryland Heights

940 West Port Plaza, Suite 450
Maryland Heights, MO 63146
(913) 685-5109
Claims: 800-842-9621

Kansas City

7465 West 132nd
Overland Park, KS 66213
(913) 685-5109
Claims: 800-255-5072

Missouri Workers'

Compensation Plan (MWCP)

1000 Walnut Street
Kansas City, MO 64199
(816) 391-1123

MONTANA

Portland, OR

4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276

NEBRASKA

Omaha

11516 Miracle Hills Dr., St. 400
Omaha, NE 68154
(651) 310-4422
Claims: 800-255-5072

NEVADA

Las Vegas

1850 E Flamingo, Suite 202
Las Vegas, NV 89119
(702) 669-4746
Claims: 702-479-4200

NEW HAMPSHIRE

Portland, ME

207 Larrabee Road, Suite 3
Westbrook, ME 04092
(207) 857-2021

NEW JERSEY

Morristown

445 South Street
Morristown, NJ 07646
(973) 631-7015
Claims: 1-800-842-2475

NEW JERSEY

Marlton

Lake Center Exec Park Building 30
Suite 110
Marlton, NJ 08053
(856) 703-2323
Claims: 800-842-2475

NEW MEXICO

Phoenix

2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
(720) 200-8355
Claims: 602-861-8600

NEW YORK

Albany

900 Watervliet-Shaker Road
Albany, NY 12205
(315) 424-7231
Claims: 800-842-2475

NEW YORK

Buffalo

60 Lakefront Blvd.
P.O. Box 242
Buffalo, NY 14240-0242
(315) 424-7231
Claims: 800-842-2475

NEW YORK

Jericho-Long Island

Two Jericho Plaza
Jericho, NY 11753
(516) 933-3932
Claims: 800-842-2475

NEW YORK

New York

485 Lexington Ave.
New York, NY 10017-2630
(516) 933-3932
Claims: 1-800-842-2475

**Please call these numbers
FOR SAFETY SERVICES ONLY**

For all other inquiries please contact your agent, underwriter or claim representative

NEW YORK

Rochester

75 Town Centre Drive
P.O. Box 23235
Rochester, NY 14692-3235
(315) 424-7231
Claims: 1-800-842-2475

NEW YORK

Syracuse

440 South Warren Street
P.O. Box 4963
Syracuse, NY 13221-4963
(315) 424-7231
Claims: 800-842-2475

NORTH CAROLINA

Charlotte

11440 Carmel Commons Blvd.
P.O. Box 473500
Charlotte, NC 28247-3500
(704) 540-3438
Claims: (704) 544-3500

NORTH CAROLINA

Raleigh

4504 Emperor Blvd.
Durham, NC 27703
(919) 474-4811
Claims: (704) 544-3500

NORTH DAKOTA

St. Paul, MN

385 Washington St., MC 104P
St. Paul, MN 55102
(651) 310-4422
Claims: 800-842-3073

OHIO

Cincinnati

895 Central Ave., Ste. 800
Cincinnati, OH 45202
(317) 845-1479
Claims: 800-238-6210

OHIO

Cleveland

Skylight Office Tower
1660 W. 2nd St., Ste. 500
Cleveland, OH 44113-1454
(317) 845-1479
Claims: 800-238-6210

OKLAHOMA

Tulsa

9820 East 41st St., Suite 401
P.O. Box 3510
Tulsa, OK 74101
(918) 624-2730

OREGON

Portland

4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
(503) 534-4276
Claims: 800-698-6883

PENNSYLVANIA

Philadelphia

10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
(215) 274-1610
Claims: 800-832-0606

PENNSYLVANIA

Pittsburgh

800 Two Chatham Center
Pittsburgh, PA 15219-2505
(412) 338-3082
Claims: (412) 338-3000

PENNSYLVANIA

Reading

1105 Berkshire Blvd.
P.O. Box 13426
Wyomissing, PA 19612-3426
(215) 274-1610
Claims: 800-832-0606

RHODE ISLAND

Braintree

350 Granite Street
Suite 1201
Braintree, MA 02184
(781) 817-8370
Claims: 800-832-7839

SOUTH CAROLINA

Charlotte

11440 Carmel Commons Blvd.
P.O. Box 473500
Charlotte, NC 28247-3500
(704) 540-3438
Claims: 704-544-3500

SOUTH DAKOTA

St. Paul, MN

385 Washington St.
St. Paul, MN 55102
(651) 310-4422
Claims: 800-842-3073

TENNESSEE

Franklin

6640 Carothers Pkwy, Suite 300
Franklin, TN 37067
(615) 660-6036
Claims: (615) 660-6000

TEXAS

Dallas

1301 E Collins Blvd., Suite 300
Richardson, TX 75081
(214) 570-6675
Claims: 214-570-6000

TEXAS

Houston

4650 Westway Park Blvd., Suite 350
Houston, TX 77041
(281) 606-8534
Claims: 800-235-3610

UTAH

Denver, CO

6060 S. Willow Drive #300
Greenwood Village, CO 80111
(720) 200-8306
Claims: 800-453-3025

VERMONT

Hartford, CT

300 Windsor Street
Hartford, CT 06120
(860) 954-5190

VIRGINIA

Richmond

300 Arboretum Place
P.O. Box 26426
Richmond, VA 23260-6426
(804) 330-6063
Claims: (804) 330-6000

Washington, DC

14200 Park Meadow Dr.
Chantilly, VA 20151
(571) 287-6232
Claims: 800-368-3562

WASHINGTON

Seattle

1501 4th Avenue, Suite 400
Seattle, WA 98101
(206) 464-3463

WEST VIRGINIA

Pittsburgh, PA

800 Two Chatham Center
Pittsburgh, PA 15219-2502
(412) 338-3082
Claims: (443) 353-1000

WISCONSIN

Milwaukee

13935 Bishops Drive, Suite 200
Brookfield, WI 53005
(262) 825-9203
Claims: 800-842-6172

WYOMING

Denver, CO

6060 S. Willow Drive #300
Greenwood Village, CO 80111
(720) 200-8306

Important Notice to Policy Holders in California

Your policy contains the following form:

WC 04 03 17 00 – Employee Insured by General Employer

If, in the conduct of your business in California, you have employees provided to you pursuant to an agreement with another employer (the "General Employer"), this endorsement is intended to prevent your workers' compensation policy from responding to work related injuries to such employees in the event the General Employer's workers' compensation carrier becomes insolvent. Such an agreement may exist, for example, if you hire temporary employees through an agency, or contract with an employee leasing company.

In order for exclusion WC 04 03 17 00 to be effective, you must countersign the form. Sign and return the form if you want to avoid this exposure under your policy, if you have a valid and enforceable agreement with the General Employer in which the General Employer has agreed to obtain workers' compensation coverage for the employees, and if the General Employer has obtained such workers' compensation coverage. With this exclusion in place on your policy, an injured employee you hired through a temporary agency or under contract with an employee leasing company would submit the claim to the California Insurance Guarantee Association (CIGA) in the event the temporary agency's or employee leasing company's workers' compensation carrier becomes insolvent. Without the signed exclusion, CIGA may not pay such claims, resulting in increased exposure under your policy.

Signed forms should be sent to your agent or broker.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 04 03 17 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE
Employee Insured by General Employer Excluded

The insurance under this policy is limited as follows:

It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

**NO LIABILITY FOR
EMPLOYEE INSURED BY
GENERAL EMPLOYER**

Any liability you may have as the special employer of an employee who is not on your payroll at the time of injury, based upon your representation that: (1) you have entered into a valid and enforceable agreement pursuant to Labor Code Section 3602 (d) with the employee's general employer under which the general employer agrees to secure the payment of compensation for such employee and (2) the general employer has obtained workers' compensation coverage for the employee.

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES, AND OTHER SUBSTANTIAL PENALTIES (Labor Code Section 3710.1, et seq.).

By signature below, you affirm that, with respect to any employee who is also the employee of a general employer, (1) you have entered into a valid and enforceable agreement pursuant to Labor Code Section 3602(d) with the employee's general employer under which the general employer agrees to secure the payment of compensation for such employee and (2) the general employer has obtained workers' compensation coverage for the employee.

Countersigned By _____

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Insurance Company

Countersigned by _____

POLICYHOLDER NOTICE

SHORT RATE CANCELLATION

CALIFORNIA INSURANCE CODE SECTION 481

CA Insurance Code Section 481 requires that where an insurance policy includes a provision to refund premium on anything other than a pro rata basis, including the assessment of cancellation fees, the insurer must disclose that fact to the policyholder in writing prior to, or concurrent with, the proposal or quote prior to each renewal. The disclosure must include the actual or maximum fees or penalties to be applied. The WCIRB also created a Short Rate Cancellation Endorsement which complements the disclosure requirement. This requirement applies to insurance policies issued or renewed on or after January 1, 2012.

In order to respond to this insurance code requirement we have created this Policyholder Notice to disclose our use of short rate calculations as described in the California Short Rate Cancellation Endorsement included in the policy.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

A Custom Insurance Policy Prepared for:

**GARDEN FRESH RESTAURANT CORP
15822 BERNARDO CENTER DRIVE
SAN DIEGO CA 92127**



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

RENEWAL OF (TRJUB-4246B09-2-13)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

1.

NCCI CO CODE: 13579

INSURED:

GARDEN FRESH RESTAURANT CORP
15822 BERNARDO CENTER DRIVE
SAN DIEGO CA 92127

PRODUCER:

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

Insured is A CORPORATION

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

2. The policy period is from 04-01-14 to 04-01-15 12:01 A.M. at the insured's mailing address.

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

AZ CA CO FL GA IL KS MO NC NM NV OR TX UT

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

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

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

AL AR CT DC DE HI IA ID IN KY LA MA MD ME MI MN MS MT NE NH NJ NY
OK PA RI SC SD TN VA VT WI WV

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

DATE OF ISSUE: 04-15-14 LC
OFFICE: LOS ANGELES CA 105
PRODUCER: LOCKTON COMPANIES LLC

NA287



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION SCHEDULE:

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

SIC-CODE: 5812 NAICS: 722511

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$ 2607674	EXCESS NONE
PREMIUM DISCOUNT	TO BE DETERMINED	
OTHER CHARGES & CREDITS	210	NONE
0900-12 EXPENSE CONSTANT		280
TERRORISM	INCLUDED	
CAT (OTHER THAN CERT ACTS OF TERRORISM)	INCLUDED	
TOTAL ESTIMATED PREMIUM	2607674	280
TAXES AND SURCHARGES	75833	3
DEPOSIT AMOUNT DUE	2683507	283
	AMS BINDER BILLED #	
	236704	

Minimum Premium: \$ 1250

EMPLOYERS LIABILITY MINIMUM: \$ 150

OTHER MINIMUMS ARE INDICATED ON THE APPLICABLE SCHEDULE(S)

DATE OF ISSUE: 04-15-14 LC

OFFICE: LOS ANGELES CA 105

PRODUCER: LOCKTON COMPANIES LLC NA287

COUNTERSIGNED-AGENT



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-AZ

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

9029 E INDIAN BEND RD
SCOTTSDALE, AZ 85250-8521
SIC CODE: 5812 NAICS: 722511

1410 EAST SOUTHERN AVE
TEMPE, AZ 85282-5612
SIC CODE: 5812 NAICS: 722511

4420 NORTH STONE AVE
TUCSON, AZ 85705-1603
SIC CODE: 5812 NAICS: 722511

52 EAST CAMELBACK RD
PHOENIX, AZ 85012-1662
SIC CODE: 5812 NAICS: 722511

7565 WEST BELL ROAD
SUITE 1
PEORIA, AZ 85382-3829
SIC CODE: 5812 NAICS: 722511

4723 E RAY ROAD
SUITE 1
PHOENIX, AZ 85044-6230
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
6202 E BROADWAY BLVD
TUCSON, AZ 85711-4008
SIC CODE: 5812 NAICS: 722511

10046 NORTH 26TH DRIVE
PHOENIX, AZ 85021
SIC CODE: 5812 NAICS: 722511

21001 NORTH TATUM BLVD
#93
PHOENIX, AZ 85050
SIC CODE: 5812 NAICS: 722511

4928 S POWER RD
MESA, AZ 85212
SIC CODE: 5812 NAICS: 722511

331 S RIVER DRIVE #10
TEMPE, AZ 85281
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SOUPLANTATION

NO BUSINESS LOCATION
NONE, AZ 85001
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, AZ 85001
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	571241	.47	2685
RESTAURANT: FAST FOOD	9083	6223129	1.67	103926
RESTAURANT: FAST FOOD	9083U	IF ANY	1.87	

AZ MANUAL PREMIUM \$ 106611

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 1173	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	107784	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	109940	NONE
DEVIATION PROGRAM CREDIT (9034) - 20.00%	21988	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	87952	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	87952	NONE
DEPOSIT AMOUNT DUE	87952	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

050
13579-CA

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 2617464

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP

15822 BERNARDO CENTER DRIVE

SAN DIEGO, CA 92127

SIC CODE: 5812 NAICS: 722511

1850 RAYMER AVENUE

FULLERTON, CA 92833

SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SOUPLANTATION

6171 MISSION GORGE RD

SAN DIEGO, CA 92129

SIC CODE: 5812 NAICS: 722511

3960 WEST POINT LOMA BLVD

SAN DIEGO, CA 92110

SIC CODE: 5812 NAICS: 722511

9158 FLETCHER PKWY

LA MESA, CA 91942-3424

SIC CODE: 5812 NAICS: 722511

5939 WEST CHAPMAN AVE

GARDEN GROVE, CA 92845-1662

SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
4720 CANDLEWOOD STREET
LAKEWOOD, CA 90712-1831
SIC CODE: 5812 NAICS: 722511

1860 MARRON ROAD
CARLSBAD, CA 92008-1172
SIC CODE: 5812 NAICS: 722511

201 SOUTH LAKE AVE
PASADENA, CA 91101
SIC CODE: 5812 NAICS: 722511

8105 MIRA MESA BLVD
SAN DIEGO, CA 92126-2601
SIC CODE: 5812 NAICS: 722511

21309 S HAWTHORNE BLVD
TORRANCE, CA 90503-5602
SIC CODE: 5812 NAICS: 722511

301 E HUNTINGTON DRIVE
ARCADIA, CA 91006-3747
SIC CODE: 5812 NAICS: 722511

555 POINTER DR
BUILDING #2
BREA, CA 92821-3672
SIC CODE: 5812 NAICS: 722511

8966 FOOTHILL BLVD
RANCHO CUCAMONGA, CA 91730-3447
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
1555 ADAMS AVENUE
COSTA MESA, CA 92626-3814
SIC CODE: 5812 NAICS: 722511

2131 W COMMONWEATLH AVE
ALHAMERA, CA 91803-1403
SIC CODE: 5812 NAICS: 722511

100 N LA CIENEGA
E-3
LOS ANGELES, CA 90048-5086
SIC CODE: 5812 NAICS: 722511

11911 SAN VICENTE BLVD
SUITE 116
LOS ANGELES, CA 90049-5086
SIC CODE: 5812 NAICS: 722511

11179 TALBERT AVE
FOUNTAIN VALLEY, CA 92708-5406
SIC CODE: 5812 NAICS: 722511

228 WEST HOSPITALITY LANE
SAN BERNARDINO, CA 92498-3268
SIC CODE: 5812 NAICS: 722511

17210 BERNARDO CENTER DR
SAN DIEGO, CA 92128
SIC CODE: 5812 NAICS: 722511

23870 ALISO CREEK RD
LAGUNA NIGUEL, CA 92677-3907
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
3804 VALLEY CENTRE DRIVE
SAN DIEGO, CA 92130-2331
SIC CODE: 5812 NAICS: 722511

7095 CLAIREMONT MESA BLVD
SAN DIEGO, CA 92111-1002
SIC CODE: 5812 NAICS: 722511

26420 YNEZ ROAD
TEMECULA, CA 92591
SIC CODE: 5812 NAICS: 722511

375 WEST VENTURA BLVD
CAMARILLO, CA 93010
SIC CODE: 5812 NAICS: 722511

1860 UNIVERSITY DRIVE
VISTA, CA 92083-7700
SIC CODE: 5812 NAICS: 722511

17411 COLIMA ROAD
CITY OF INDUSTRY, CA 91748
SIC CODE: 5812 NAICS: 722511

19801 RINALDI STREET
NORTHRIDGE, CA 91326
SIC CODE: 5812 NAICS: 722511

2825 MAIN STREET
IRVINE, CA 92614
SIC CODE: 5812 NAICS: 722511

26572 TOWNE CENTER DRIVE
FOOTHILL RANCH, CA 92610-2417

SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
1901 W. MALVERN AVE
FULLERTON, CA 92833
SIC CODE: 5812 NAICS: 722511

1810 MAIN COURT
CHULA VISTA, CA 91911
SIC CODE: 5812 NAICS: 722511

1555 SIMI TOWN CENTER WAY
#582
SIMI VALLEY, CA 93065
SIC CODE: 5812 NAICS: 722511

40026 10TH ST WEST
PALMDALE, CA 93551
SIC CODE: 5812 NAICS: 722511

79705 STATE HIGHWAY 111
LA QUINTA, CA 92253
SIC CODE: 5812 NAICS: 722511

109 N EL CAMINO REAL
ENCINITAS, CA 92024
SIC CODE: 5812 NAICS: 722511

13681 NEWPORT AVE #1
TUSTIN, CA 92780-4689
SIC CODE: 5812 NAICS: 722511

24303 TOWN CENTRE DR
STE 150
VALENCIA, CA 91355
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)

DBA SWEET TOMATOES

NO BUSINESS LOCATION
NONE, CA 94203
SIC CODE: 5812 NAICS: 722511

39370 PASEO PADRE PKWY
FREMONT, CA 94538-1629
SIC CODE: 5812 NAICS: 722511

7114 NORTH FRESNO ST
FRESNO, CA 93279-2905
SIC CODE: 5812 NAICS: 722511

40-A CRESCENT DRIVE
PLEASANT HILL, CA 94523
SIC CODE: 5812 NAICS: 722511

113 BERNAL ROAD
SAN JOSE, CA 95119
SIC CODE: 5812 NAICS: 722511

625 COLEMAN AVE
SAN JOSE, CA 95110
SIC CODE: 5812 NAICS: 722511

4501 HOPYARD ROAD
SUITE 1
PLEASANTON, CA 94588-2765
SIC CODE: 5812 NAICS: 722511

1210 KIFER RD
SUNNYVALE, CA 94086

SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
6800 Sycamore Canyon Blvd
Riverside, CA 92507
SIC CODE: 5812 NAICS: 722511

1260 A/B AUTO PARKWAY
ESCONDIDO, CA 92029
SIC CODE: 5812 NAICS: 722511

6081 CENTER DRIVE
SUITE 102
LOS ANGELES, CA 90045
SIC CODE: 5812 NAICS: 722511

2681 GATEWAY ROAD
#G
CARLSBAD, CA 92009
SIC CODE: 5812 NAICS: 722511

1040 GRANT ROAD
BUILDING A SUITE 350
MOUNTAIN VIEW, CA 94040
SIC CODE: 5812 NAICS: 722511

4180 NORTH 1ST STREET
SPACE 500-4
SAN JOSE, CA 95134
SIC CODE: 5812 NAICS: 722511

2921 LOS FELIZ BLVD
LOS ANGELES, CA 90039
SIC CODE: 5812 NAICS: 722511

4645 CHINO HILLS PARKWAY
CHINO HILLS, CA 91709
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 273961376 ENTITY CD 002 (CONT'D)				
GARDEN FRESH PROMOTIONS LLC A CALIFORNIA LIMITED LIABILITY COMPANY				
NO BUSINESS LOCATION NONE, CA 94203 SIC CODE: 5812 NAICS: 722511				
BLANKET WAIVER SEE ENDT WC 99 03 76(A)-001 WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	1562541	.00	
SALESPERSONS-OUTSIDE	8742	2397608	.55	13187
CLERICAL OFFICE EMPLOYEES NOC	8810	8039539	.44	35374
RESTAURANTS OR TAVERNS-ALL EMPLOYEES-INCLUDING MUSICIANS AND ENTERTAINERS	9079	37755109	4.01	1513980



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANTS OR TAVERNS-ALL EMPLOYEES-INCLUDING MUSICIANS AND ENTERTAINERS USL HW-SEE ENDT WC 99 01 01 MANRATE 4.0100	9079U	IF ANY	8.02	

CA MANUAL PREMIUM \$ 1562541

	STANDARD	EXCESS
BALANCE TO WAIVER MINIMUM PREMIUM	\$ 250	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	1562791	0
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	1594047	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1594047	0
2.25% CIGA SURCHARGE	35866	0
2.23% USER / FRAUD / UEBT / SIBT / OSH / LEC	35547	0
TOTAL ESTIMATED PREMIUM	1665460	0
DEPOSIT AMOUNT DUE	1665460	0



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)
POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-CO

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001
STATE UNEMPLOYMENT IDENTIFIER: 494179008

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

14015 EAST EVANS AVE
AURORA, CO 80014
SIC CODE: 5812 NAICS: 722511

8971 YATES STREET
WESTMINSTER, CO 80031
SIC CODE: 5812 NAICS: 722511

7736 WEST LONG DRIVE
LITTLETON, CO 80123
SIC CODE: 5812 NAICS: 722511

9445 PARK MEADOWS DRIVE
LONE TREE, CO 80124
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, CO 80201
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	2633446	1.79	47139

CO MANUAL PREMIUM \$ 47139

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 519	\$	NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	47658		NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	48611		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	48611		NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE		NONE
TOTAL ESTIMATED PREMIUM	48611		NONE
DEPOSIT AMOUNT DUE	48611		NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

15318-FL

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001
STATE UNEMPLOYMENT IDENTIFIER: 1221255

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

31151 US HIGHWAY
19 NORTH
PALM HARBOR, FL 34684
SIC CODE: 5812 NAICS: 722511

13101 SEMINOLE BLVD
LARGO, FL 33778-2127
SIC CODE: 5812 NAICS: 722511

14703 NORTH DALE MABRY HWY
TAMPA, FL 33618-2025
SIC CODE: 5812 NAICS: 722511

1902 N. DALE MABRY HWY
TAMPA, FL 33607-2522
SIC CODE: 5812 NAICS: 722511

10017 ADAMO DRIVE
TAMPA, FL 33619-2619
SIC CODE: 5812 NAICS: 722511

801 SOUTH UNIVERSITY DRIVE
BLDG K STE 101
PLANTATION, FL 33324-3334
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
4994 SOUTH TAMiami TRAIL
SARASOTA, FL 34231-4354
SIC CODE: 5812 NAICS: 722511

14080 SOUTH TAMiami TRAIL
FORT MYERS, FL 33912-1632
SIC CODE: 5812 NAICS: 722511

474 W STATE ROAD 436
ALTAMONTE SPRINGS, FL 32714-4147
SIC CODE: 5812 NAICS: 722511

2906 OAKWOOD BLVD
HOLLYWOOD, FL 33020-7122
SIC CODE: 5812 NAICS: 722511

6245 N ANDREWS AVE
FT LAUDERDALE, FL 33309-2139
SIC CODE: 5812 NAICS: 722511

1850 UNIVERSITY DRIVE
CORAL SPRINGS, FL 33071-6031
SIC CODE: 5812 NAICS: 722511

1625 WELLS RD
ORANGE PARK, FL 32073
SIC CODE: 5812 NAICS: 722511

6877 SOUTH KIRKMAN RD
ORLANDO, FL 32819
SIC CODE: 5812 NAICS: 722511

4678 E COLONIAL DRIVE
ORLANDO, FL 32803-4357
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
1115 MARY SUSAN DRIVE
JACKSONVILLE, FL 32246
SIC CODE: 5812 NAICS: 722511

15901 PINES BLVD
PEMBROKE PINES, FL 33027
SIC CODE: 5812 NAICS: 722511

7110 BERACASA WAY
SPACE #42-45
BOCA RATON, FL 33433-3448
SIC CODE: 5812 NAICS: 722511

1900 PALM BEACH LAKES BLVD
WEST PALM BEACH, FL 33409
SIC CODE: 5812 NAICS: 722511

12561 S APOPKA VINELAND ROAD
ORLANDO, FL 32836
SIC CODE: 5812 NAICS: 722511

10940 TAMiami TRAIL NORTH
NAPLES, FL 34110
SIC CODE: 5812 NAICS: 722511

1100 N CONGRESS AVE
BOYNTON BEACH, FL 33426
SIC CODE: 5812 NAICS: 722511

5407 UNIVERSITY PARKWAY
BRADENTON, FL 34201
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
8405 MILLS DRIVE
SUITE 220
MIAMI, FL 33183
SIC CODE: 5812 NAICS: 722511

10156 US HIGHWAY 19
PORT RICHEY, FL 34668-3743
SIC CODE: 5812 NAICS: 722511

3236 ROLLING OAKS BLVD
KISSIMMEE, FL 34747
SIC CODE: 5812 NAICS: 722511

508 US H IGHWAY 27/441
LADY LAKE, FL 32159
SIC CODE: 5812 NAICS: 722511

120-126 COMPTON AVE
ORLANDO, FL 32806
SIC CODE: 5812 NAICS: 722511

2689 GULF TO BAY BLVD
SUITE 1840
CLEARWATER, FL 33759
SIC CODE: 5812 NAICS: 722511

31151 US 19 NORTH
PALM HARBOR, FL 34684
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002
GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 273961376 ENTITY CD 002 (CONT'D)				
NO BUSINESS LOCATION				
NONE, FL				
SIC CODE: 5812 NAICS: 722511				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	931318	.52	4843
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	
CLERICAL TELECOMMUTER EMPLOYEES	8871	IF ANY	.31	
RESTAURANT: FAST FOOD	9083	15406689	2.74	422143

FL MANUAL PREMIUM \$ 426986

	STANDARD	EXCESS
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 5978	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	432964	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	441623	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	441623	NONE
TOTAL ESTIMATED PREMIUM	441623	NONE
DEPOSIT AMOUNT DUE	441623	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-GA

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP

1325 CHASTAIN ROAD
SUITE 300
KENNESAW, GA 30144
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

1125 ERNEST BARRETT PKWY
KENNESAW, GA 30144-4534
SIC CODE: 5812 NAICS: 722511

3505 MALL BLVD
DULUTH, GA 30096-4710
SIC CODE: 5812 NAICS: 722511

6350 PEACHTREE-DUNWOODY RD
ATLANTA, GA 30328-4527
SIC CODE: 5812 NAICS: 722511

950 NORTH POINT DRIVE
ALPHARETTA, GA 30005
SIC CODE: 5812 NAICS: 722511

6340 PEACHTREE-DUNWOODY RD.
ATLANTA, GA 30328
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

DATE OF ISSUE: 04-15-14 LC

SCHEDULE NO: 20 OF MORE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 273961376 ENTITY CD 002 (CONT'D)				
GARDEN FRESH PROMOTIONS LLC A CALIFORNIA LIMITED LIABILITY COMPANY				
NO BUSINESS LOCATION NONE, GA 30301 SIC CODE: 5812 NAICS: 722511				
DRIVERS, CHAUFFEURS, MESSENG- ERS, AND THEIR HELPERS NOC- COMMERCIAL	7380	530564	8.09	42923
SALESPERSONS-OUTSIDE	8742	167427	.55	921
RESTAURANT: FAST FOOD	9083	2619687	3.41	89331

GA MANUAL PREMIUM \$ 133175

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 1465	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	134640	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	137333	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	137333	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	137333	NONE
DEPOSIT AMOUNT DUE	137333	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-IL

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP

875 CAMBRIDGE DRIVE
ELK GROVE VILLAGE, IL 60007
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

2801 E MAIN ST
ST CHARLES, IL 60174
SIC CODE: 5812 NAICS: 722511

2351 WILLOW ROAD
GLENVIEW, IL 60025-7637
SIC CODE: 5812 NAICS: 722511

1951 E MCCONNER PKWY
SCHAUMBURG, IL 60173
SIC CODE: 5812 NAICS: 722511

850 S WAUKEGAN RD
WAUKEGAN, IL 60085
SIC CODE: 5812 NAICS: 722511

2820 HIGHLAND AVE
SPACE A
LOMBARD, IL 60148
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
FEIN 330028786 ENTITY CD 001 (CONT'D) 986 NORTH ROUTE 59 AURORA, IL 60504 SIC CODE: 5812 NAICS: 722511				
FEIN 273961376 ENTITY CD 002				
GARDEN FRESH PROMOTIONS LLC A CALIFORNIA LIMITED LIABILITY COMPANY				
NO BUSINESS LOCATION NONE, IL SIC CODE: 5812 NAICS: 722511				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	160256	.42	673



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	3646385	2.18	79491

IL MANUAL PREMIUM \$ 80164

	STANDARD	EXCESS
1.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 1122	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	81286	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	82912	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	82912	NONE
EXPENSE CONSTANT (0900)	NONE	280
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
1.01% IL IND COMM OP FUND SURCHARGE	837	3
TOTAL ESTIMATED PREMIUM	83749	283
DEPOSIT AMOUNT DUE	83749	283



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-KS

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

8505 COLLEGE BOULEVARD
OVERLAND PARK, KS 66210-1836
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, KS 66601
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	476641	1.44	6864

KS MANUAL PREMIUM \$ 6864

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 76	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	6940	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	7079	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	7079	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	7079	NONE
DEPOSIT AMOUNT DUE	7079	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

13439-MO

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

1309 MEADOW LAKE PARKWAY
KANSAS CITY, MO 64114-1619
SIC CODE: 5812 NAICS: 722511

10401 OLIVE BLVD
CREVE COEUR, MO 63141
SIC CODE: 5812 NAICS: 722511

9846 WATSON ROAD
CRESTWOOD, MO 63126
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, MO 65101
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	1657152	1.55	25686

MO MANUAL PREMIUM \$ 25686

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 283	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	25969	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	26488	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	26488	NONE
6.00% MO SECOND INJURY FUND SURCHARGE	1589	NONE
1.00% MO ADMINISTRATIVE SURCHARGE	NONE	NONE
TOTAL ESTIMATED PREMIUM	28077	NONE
DEPOSIT AMOUNT DUE	28077	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE PHOENIX INSURANCE COMPANY

12610-NC

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 330028786 ENTITY CD 001				
GARDEN FRESH RESTAURANT CORP DBA SWEET TOMATOES				
5200 CAPITAL BLVD RALEIGH, NC 27616 SIC CODE: 5812 NAICS: 722511				
2310 WALNUT ST CARY, NC 27511 SIC CODE: 5812 NAICS: 722511				
FEIN 273961376 ENTITY CD 002				
GARDEN FRESH PROMOTIONS LLC A CALIFORNIA LIMITED LIABILITY COMPANY				
NO BUSINESS LOCATION NONE, NC SIC CODE: 5812 NAICS: 722511				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	116833	.44	514
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.19	



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	1047316	1.60	16757

NC MANUAL PREMIUM \$ 17271

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 190	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	17461	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	17810	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	17810	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	17810	NONE
DEPOSIT AMOUNT DUE	17810	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-ND

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 330028786 ENTITY CD 001				
GARDEN FRESH RESTAURANT CORP				
NO BUSINESS LOCATION				
NONE, ND 58401				
SIC CODE: 5812 NAICS: 722511				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM	\$	STANDARD	EXCESS
LOSS CONSTANT (0032)		NONE	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1	NONE
TOTAL ESTIMATED PREMIUM		1	NONE
DEPOSIT AMOUNT DUE		1	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE PHOENIX INSURANCE COMPANY

12610-NM

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001
STATE UNEMPLOYMENT IDENTIFIER: 1911861

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

4901 SAN MATEO BLVD NE
ALBUQUERQUE, NM 87109-2465
SIC CODE: 5812 NAICS: 722511

10126 COORS BOULEVARD
NORTHWEST
ALBUQUERQUE, NM 87114-4022
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, NM 87500
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	1164439	1.59	18515

NM MANUAL PREMIUM \$ 18515

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 204	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	18719	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	19093	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	19093	NONE
TOTAL ESTIMATED PREMIUM	19093	NONE
DEPOSIT AMOUNT DUE	19093	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

15318-NV

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

2080 N RAINBOW BLVD
LAS VEGAS, NV 89108-7049
SIC CODE: 5812 NAICS: 722511

375 NORTH STEPHANIE ST
SUITE 111
HENDERSON, NV 89014
SIC CODE: 5812 NAICS: 722511

9460 W FLAMINGO ROAD
SUITE 100
LAS VEGAS, NV 89147
SIC CODE: 5812 NAICS: 722511

10520 SOUTH EASTERN AVE
SUITE 130
HENDERSON, NV 89052
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, NV 89701
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
SALESPERSONS OR COLLECTORS - OUTSIDE	8742	126084	.76	958
RESTAURANT: FAST FOOD	9083	1823798	1.58	28816

NV MANUAL PREMIUM \$ 29774

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 328	\$	NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	30102	\$	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	30704		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	30704		NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE		NONE
TOTAL ESTIMATED PREMIUM	30704		NONE
DEPOSIT AMOUNT DUE	30704		NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-OH

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 330028786 ENTITY CD 001				
GARDEN FRESH RESTAURANT CORP				
NO BUSINESS LOCATION				
NONE, OH 45202				
SIC CODE: 5812 NAICS: 722511				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM	\$	STANDARD	EXCESS
LOSS CONSTANT (0032)		NONE	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1	NONE
TOTAL ESTIMATED PREMIUM		1	NONE
DEPOSIT AMOUNT DUE		1	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

15318-OR

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001
STATE UNEMPLOYMENT IDENTIFIER: 9238531

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

1225 N W WATERHOUSE AVE
BEAVERTON, OR 97006-5700
SIC CODE: 5812 NAICS: 722511

13011 SE 84TH AVE
CLACKAMAS, OR 97015
SIC CODE: 5812 NAICS: 722511

6600 SW CARDINAL LANE
TIGARD, OR 97224
SIC CODE: 5812 NAICS: 722511

10350 N VANCOUVER WAY
PORTLAND, OR 97217
SIC CODE: 5812 NAICS: 722511

2026 NE COLUMBIA BLVD
PORTLAND, OR 97211
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SOUPLANTATION

NO BUSINESS LOCATION
NONE, OR 97301
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 273961376 ENTITY CD 002 (CONT'D)

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, OR 97301
SIC CODE: 5812 NAICS: 722511

SALESPERSONS OR COLLECTORS - OUTSIDE	8742	IF ANY	.29
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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

RESTAURANT & DRIVERS. INCLUDES ANY OPERATION THAT PREPARES FOOD FOR CONSUMPTION EITHER ON OR OFF PREMISES BY MEANS SUCH AS, BUT NOT LIMITED TO, COOKING, HEATING, FRYING OR BAKING AND INCLUDES SANDWICH SHOPS OR DELICATESSENS WHICH PREPARE FOODS, HOT OR COLD FOR CONSUMPTION

9079	1934514	1.63	31533
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OR MANUAL PREMIUM \$ 31533

	STANDARD	EXCESS
.40% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 126	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	31659	\$ NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	\$ 32292	\$ NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	32292	\$ NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	\$ NONE
6.20% OR TAX AND ASSESSMENT CHARGE	1994	\$ NONE
TOTAL ESTIMATED PREMIUM	34286	\$ NONE
DEPOSIT AMOUNT DUE	34286	\$ NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-TX

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

GARDEN FRESH RESTAURANT CORP

15600 TRINITY BLVD
SUITE 102
FORT WORTH, TX 76155
SIC CODE: 5812 NAICS: 722511

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

8775 KATY FREEWAY
HOUSTON, TX 77024
SIC CODE: 5812 NAICS: 722511

17240 TOMBALL PARKWAY
(HWY 249)
HOUSTON, TX 77064
SIC CODE: 5812 NAICS: 722511

12540 SUGARDALE DRIVE
STAFFORD, TX 77477-3702
SIC CODE: 5812 NAICS: 722511

1717 LAKE WOODLANDS DRIVE
THE WOODLANDS, TX 77380
SIC CODE: 5812 NAICS: 722511

15225 MONTFORT DRIVE
DALLAS, TX 75248
SIC CODE: 5812 NAICS: 722511



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

FEIN 330028786 ENTITY CD 001 (CONT'D)
4001 MATLOCK ROAD
ARLINGTON, TX 76015-4307
SIC CODE: 5812 NAICS: 722511

1820 MARKET PLACE BLVD
IRVING, TX 75063
SIC CODE: 5812 NAICS: 722511

2901 WEST 7TH STREET
FT WORTH, TX 76107
SIC CODE: 5812 NAICS: 722511

5500 GREENVILLE AVE UNIT 1320
DALLAS, TX 75206
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, TX
SIC CODE: 5812 NAICS: 722511

SALESPERSONS, C M-OUTSIDE	8742	242595	.24	582
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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT-FAST FOOD	9079	5192542	1.29	66984

TX MANUAL PREMIUM \$ 67566

2.00% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 1351
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	68917
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	70295
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	70295
TOTAL ESTIMATED PREMIUM	70295
DEPOSIT AMOUNT DUE	70295



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: THE PHOENIX INSURANCE COMPANY

12610-UT

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

RATE BUREAU ID: 917818258

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

FEIN 330028786 ENTITY CD 001

STATE UNEMPLOYMENT IDENTIFIER: 199858000100000

GARDEN FRESH RESTAURANT CORP
DBA SWEET TOMATOES

7455 S UNION PARK AVE
MIDVALE, UT 84047-1811
SIC CODE: 5812 NAICS: 722511

10060 S STATE ST
SANDY, UT 84070
SIC CODE: 5812 NAICS: 722511

FEIN 273961376 ENTITY CD 002
STATE UNEMPLOYMENT IDENTIFIER: 319985800000000

GARDEN FRESH PROMOTIONS LLC
A CALIFORNIA LIMITED LIABILITY
COMPANY

NO BUSINESS LOCATION
NONE, UT 84101
SIC CODE: 5812 NAICS: 722511

SALESPERSONS OR COLLECTORS -
OUTSIDE

8742	144351	.27	390
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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
RESTAURANT: FAST FOOD	9083	1104267	.95	10491

UT MANUAL PREMIUM \$ 10881

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 120	\$ NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	11001	NONE
EXPERIENCE MODIFICATION: 1.02 MODIFIED PREMIUM	11221	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	11221	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	11221	NONE
DEPOSIT AMOUNT DUE	11221	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WA

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 330028786 ENTITY CD 001				
GARDEN FRESH RESTAURANT CORP DBA SWEET TOMATOES				
12601 SE 2ND CIRCLE VANCOUVER, WA 98684-6059 SIC CODE: 5812 NAICS: 722511				
RESTAURANT NOC INCLUDED IN ** OTHER CHARGES	9079	955992	.0220	210

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM	\$	STANDARD	EXCESS	
LOSS CONSTANT (0032)		NONE	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1		NONE
** OTHER PREMIUM CHARGES		1		NONE
TOTAL ESTIMATED PREMIUM		210		NONE
DEPOSIT AMOUNT DUE		211		NONE
		211		NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WY

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

RATING MODE: RETRO

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 330028786 ENTITY CD 001				
GARDEN FRESH RESTAURANT CORP				
NO BUSINESS LOCATION				
NONE, WY 53714				
SIC CODE: 5812 NAICS: 722511				
SALESPERSONS-OUTSIDE	8742	IF ANY	.0220	

EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM	\$	STANDARD	EXCESS
LOSS CONSTANT (0032)		NONE	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		1	NONE
TOTAL ESTIMATED PREMIUM		1	NONE
DEPOSIT AMOUNT DUE		1	NONE



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE

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

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 04 03 17 00 - 001	ENDT AGRMNT LIMITING & RESTRICTING INS
WC 24 04 06 C - 001	MO EMPLOYER PAID MEDICAL ENDT
WC 36 03 06 00 - 001	OREGON LIMITS OF LIABILITY
WC 36 06 02 00 - 001	OREGON CONFIDENTIALITY ENDORSEMENT
WC 00 01 06 A - 001	LONGSHORE AND HARBOR WC ACT COVERAGE
WC 00 01 14 00 - 001	PENDING LAW CHANGE TO TERRORISM RISK INS
WC 00 03 03 C - 001	EMPLOYERS LIAB COVERAGE ENDT
WC 00 03 11 A - 001	VOLUNTARY COMP AND EMPLOYERS LIAB COV
WC 00 03 11 00 - 001	VOL COMP AND EMP LIAB COV END
WC 00 03 13 00 - 001	WAIVER OF OUR RIGHT TO RECOVER
WC 00 04 14 00 - 001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC 00 04 22 A - 001	TERRORISM-REAUTHORIZATION ACT DISCLOSURE
WC 00 05 16 00 - 001	RETRO RATING PLAN PREM ENDT-LRARO
WC 09 05 03 00 - 001	FL RETRO RATING PLAN PREM ENDT ONE-YEAR
WC 32 03 01 C - 001	NORTH CAROLINA AMENDED COVERAGE ENDT
WC 42 01 01 00 - 001	TX PENDING LAW CHANGE TO TERRORISM RISK
WC 99 01 01 00 - 001	STATE WC COMP LAWS AND USL & H WC ACT
WC 99 03 A1 00 - 001	NOTICE OF CANCELATION
WC 99 03 C3 00 - 001	SPECIAL PROVISIONS ENDT
WC 99 03 D3 A - 001	OH EMPLOYERS LIAB COVERAGE ENDORSEMENT
WC 99 03 F3 00 - 001	CA LIMITS OF LIABILITY ENDT
WC 99 03 76 A - 001	WAIVER OF OUR RIGHTS TO RECOVER-CA
WC 99 03 97 00 - 001	WYOMING AMENDATORY ENDORSEMENT
WC 99 03 99 00 - 001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
WC 99 06 P7 00 - 001	NOTICE OF CANC OR NONRENEW BY US ENDT
WC 99 06 P8 00 - 001	FL NOTICE OF CANC OR NONRENEW BY US ENDT
WC 99 06 Q1 00 - 001	EARLIER NOTICE OF CAN OR NONRE BY US END
WC 99 06 Q2 00 - 001	MO EARLIER NOT OF CAN OR NONRE BY US END
WC 99 06 03 00 - 001	GENERAL PURPOSE ENDORSEMENT
WC 99 06 10 A - 001	AMENDED CANCELLATION CONDITION ENDT.
WC 99 06 10 00 - 001	AMENDED CANCELLATION CONDITION
WC 99 06 11 A - 001	NOTICE OF CANCELLATION
WC 99 06 36 A - 001	CANCELLATION AMENDMENT - WASHINGTON
WC 99 06 99 00 - 001	ND AMENDATORY ENDORSEMENT
W09N1I13	FL PENDING LAW CHANGE TO TERR RISK INS
WC 00 04 21 C - 001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE

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

WC 99 06 G8 E - 001	FED TERRORISM RISK INS ACT DISCLOSURE
WC 99 06 J6 B - 001	N.C. FEDERAL TERRORISM RISK INS ACT
WC 99 01 19 A - 001	TERRORISM RISK INSURANCE PROGRAM ENDT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 02 04 01 C - 001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
WC 02 06 01 00 - 001	ARIZONA CANCELATION ENDORSEMENT
WC 04 01 01 A - 001	LONGSHORE & HARBOR WC ACT ENDT - CA
WC 04 03 01 B - 001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 04 03 05 00 - 001	VOL COMP & EMPLOYERS LIAB COV ENDT.
WC 04 03 60 A - 001	CA-EMPLOYERS LIAB COV AMENDATORY ENDT
WC 04 04 22 00 - 001	CALIFORNIA SHORT-RATE CANCELATION ENDT
WC 04 06 01 A - 001	CA CANCELATION ENDT
WC 05 04 02 00 - 001	COLORADO CLASSIFICATION ENDORSEMENT
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.
WC 10 04 02 00 - 001	GA NON-COOPERATION WITH PREM AUDIT ENDT
WC 10 06 01 A - 001	GA CANC NONRENEWAL AND CHG ENDT
WC 12 06 01 D - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 15 04 01 A - 001	KANSAS FINAL PREMIUM ENDORSEMENT
WC 15 06 01 A - 001	KANSAS CANCELATION AND NONRENEWAL ENDT.
WC 24 03 02 00 - 001	MO NOTIFC OF ADD MESOTHELIOMA BEN ENDT
WC 24 06 01 B - 001	MO CANCELATION AND NON-RENEWAL ENDT.
WC 24 06 02 B - 001	MO PROPERTY & CASUALTY GUARANTY ASSOC.
WC 24 06 04 A - 001	MISSOURI AMENDATORY ENDORSEMENT
WC 27 06 01 C - 001	NV CANCELLATION AND NON RENEWAL ENDT
WC 30 03 01 00 - 001	NM SAFETY DEVICE COVERAGE ENDORSEMENT
WC 30 04 01 A - 001	NM WC PREM ADJ PROGRAM
WC 30 06 01 00 - 001	NM CANCELATION AND NONRENEWAL ENDT
WC 36 03 01 00 - 001	OREGON UNSAFE EQUIPMENT EXCLUSION END.
WC 36 04 06 00 - 001	OREGON PREMIUM DUE DATE
WC 36 06 01 E - 001	OR CANCELLATION ENDORSEMENT
WC 42 03 01 F - 001	TEXAS AMENDATORY ENDORSEMENT
WC 42 03 04 A - 001	TX WAIVER OF OUR RIGHT TO RECOVER
WC 42 04 07 00 - 001	TX AUDIT PREMIUM & RETRO PREM ENDT
WC 43 03 05 00 - 001	UTAH WAIVER OF SUBROGATION ENDORSEMENT
WC 43 06 01 00 - 001	UT WORKPLACE SAFETY PROG ENDT
WC 43 06 02 00 - 001	UTAH CANCELLATION ENDORSEMENT
WC 99 06 N1 00 - 001	FL TERR RISK INS REAUTH ACT-RETRO PLANS
WC 99 06 46 00 - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 99 06 47 00 - 001	AMENDED CANCELLATION CONDITION ENDT



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**LISTING OF ENDORSEMENTS
EXTENSION OF INFO PAGE**

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

WC 99 06 Q6 00 - 001

CALIFORNIA INSURANCE PROGRAM AGREEMENT

The Travelers Insurance Companies

(Each a Stock Insurance Company)
Hartford, Connecticut

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 dis-

ease 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.

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.

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.

3. Bodily injury by accident must occur during the policy period.

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

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

States of America, its territories or possessions, or Canada.

B. We Will Pay

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

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

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

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily

injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions.
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws.
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws.
10. Bodily injury to a master or member of the crew of any vessel.
11. Fines or penalties imposed for violation of federal or state law.
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

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

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

E. We Will Also Pay

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

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Interest on a judgement 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 judgement.

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 cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

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

G. Audit

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports,

payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period

ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX – CONDITIONS

A. Inspection

We have the right, but are not 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. Cancellation

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

In witness whereof, the company has caused this policy to be signed by its President and Secretary at Hartford, Connecticut and countersigned on the Information page by a duly authorized agent of the company.



Wendy C. Shy

Secretary



Brian Mae Leon

President



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT

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

As a Missouri employer, you have the right, as provided by Section 287.957 of the Revised Statutes of Missouri, to have medical-only claims that do not exceed \$1,000 excluded from your experience modification calculation. This will only be allowed when you pay all of the employee's medical costs, there is no lost time from the employment, other than the first three days or less of disability and no claim is filed. You still must report all injuries, regardless of the dollar amount, to the Division of Workers' Compensation and to us.

However, it should be noted that if, at any time, the medical expenses that are paid "out-of-pocket" due to a particular injury should ever exceed \$1,000 in the aggregate, and/or the employee misses more than three days from work due to the injury, then this injury must be reported to us as a claim. We will pay the full amount of the claim, which includes any reimbursements due to you for past medical expenses incurred by you for this particular claim. As a result, the total amount of losses incurred by us due to this claim will be included in your experience modification calculation.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 36 03 06 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

OREGON LIMITS OF LIABILITY ENDORSEMENT

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

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

Bodily Injury by Accident	\$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each accident
Bodily Injury by Disease	\$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, policy limit
Bodily Injury by Disease	\$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each employee

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 02 (OO)

POLICY NUMBER: (TRJUB-4246B09-2-14)

OREGON CONFIDENTIALITY ENDORSEMENT

We may furnish you with certain documentation that includes confidential information. As used in this endorsement, "confidential information" means any and all medical and vocational claim records and information about an injured worker. We make this information available to you for the sole purpose of assisting us to manage, defend, or adjust claims.

1. You agree to hold all information provided by us in trust and confidence.
2. You and your employees must not disclose confidential information about an injured worker to anyone except us unless required to do so by law or with written consent of the injured worker. You will take steps necessary to protect the confidentiality of information about injured workers, including obtaining specific contractual promises from your employees and agents not to disclose any confidential information except as provided in this endorsement. You must not use confidential information for purposes other than those necessary to directly further the purposes of this endorsement.
3. You must not use confidential information in such a manner that is likely to allow other persons to know the name or identity of an injured worker, or allow other persons to know any other particulars of a worker's injury claim, except for those matters over which you as an employer have the ability and the right to direct and control. In no case can you use confidential information either singly or in concert to discriminate unlawfully against any injured worker.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 01 06 (A) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

C. Workers' Compensation Law

Workers' Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in item 3.A. of the Information Page and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

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

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

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

SCHEDULE

State	Longshore and Harbor Workers' Compensation Act Coverage Percentage
AZ	12.00
CO	44.00
FL	121.00
GA	47.00
IL	38.00
KS	56.00
MO	45.00
NC	92.00
ND	76.00
NM	68.00



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 01 06 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

SCHEDULE

STATE	LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT COVERAGE PERCENTAGE
NV	23.00
OH	155.00
OR	96.00
TX	64.00
UT	62.00
WA	101.00
WY	161.00



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

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

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

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

You need not do anything further at this time.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium:

Insurance Company

Countersigned by _____



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

POLICY NUMBER: (TRJUB-4246B09-2-14)

EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

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

This insurance does not cover:

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

SCHEDULE

States

ND WA WY

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (A) -

POLICY NUMBER: (TRJUB-4246B09-2-14)

**VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE
ENDORSEMENT**

This endorsement adds Voluntary Compensation Insurance to the policy.

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. Exclusions

This insurance does not cover:

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

D. Before We Pay

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

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

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

E. Recovery From Others

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (A)-

POLICY NUMBER: (TRJUB-4246B09-2-14)

of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers Liability Insurance

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

SCHEDULE

EMPLOYEES	STATE OF EMPLOYMENT	DESIGNATED WORKERS COMPENSATION LAW
ALL EMPLOYEES NOT SUBJECT TO THE WORKERS' COMPENSATION LAW.	ALL STATES EXCEPT CA, ND, OH, TX, WA & WY.	STATE OF HIRE.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (00) —

POLICY NUMBER: (TRJUB-4246B09-2-14)

**VOLUNTARY COMPENSATION AND
EMPLOYERS LIABILITY COVERAGE ENDORSEMENT**

This endorsement adds Voluntary Compensation Insurance to the policy.

A. HOW THIS INSURANCE APPLIES

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

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

B. WE WILL PAY

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

C. EXCLUSIONS

This insurance does not cover:

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

D. BEFORE WE PAY

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

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

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 11 (00) –

POLICY NUMBER: (TRJUB-4246B09-2-14)

E. RECOVERY FROM OTHERS

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

F. EMPLOYERS LIABILITY INSURANCE

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

SCHEDULE

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 13 (00)-01

POLICY NUMBER: (TRJUB-4246B09-2-14)

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

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

SCHEDULE

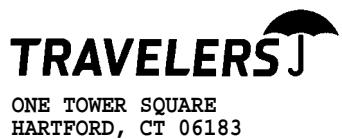
DESIGNATED PERSON:

DESIGNATED ORGANIZATION:

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

DATE OF ISSUE: 04-15-14

ST ASSIGN:



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 14 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

**TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT
DISCLOSURE ENDORSEMENT**

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

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

Definitions

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

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

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

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

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

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

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

Limitation of Liability

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

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

Policyholder Disclosure Notice

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

Schedule

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

Exposures in Alaska, Arizona and North Carolina: \$0.01 per \$100 of state remuneration, subject to final premium audit.

Exposures in Texas and Wisconsin: \$0.02 per \$100 of state remuneration, subject to final premium audit.

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured Insurance Company	Countersigned by _____	Premium \$

DATE OF ISSUE: 04-15-14 ST ASSIGN:



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 05 16 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

RETROSPECTIVE RATING PLAN PREMIUM ENDORSEMENT – LARGE RISK ALTERNATIVE RATING OPTION (LRARO)

This endorsement is issued because you chose to have the cost of the insurance rated retrospectively. This endorsement applies only to workers compensation and employers liability insurance when rated under the provisions of the Large Risk Alternative Rating Option that we have negotiated with you.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

FLORIDA RETROSPECTIVE RATING PLAN PREMIUM ENDORSEMENT ONE-YEAR PLAN

This endorsement is added to Part Five (Premium) because you chose to have the cost of the insurance rated retrospectively. This endorsement explains the rating plan and how the retrospective rating plan premium will be determined.

This endorsement applies in Florida. It determines the retrospective rating plan premium for the insurance provided by this policy and any other workers compensation policy listed in the Schedule.

The amount of retrospective rating plan premium depends on various elements.

A. Retrospective Rating Plan Premium Standard Elements

The standard elements are explained here.

1. Standard premium is the premium we would charge during the policy period if you had not chosen a retrospective rating plan. Standard premium does not include the following elements:
 - a. Expense constant
 - b. Premium resulting from the nonratable element codes in a rate or a nonratable catastrophe surcharge required by our manuals
 - c. Premium developed by the passenger seat surcharge under Classification Code 7421
 - d. Premium developed by the occupational disease rates for employers subject to the Federal Coal Mine Safety and Health Act
 - e. Premium developed by the Terrorism provisions as outlined in our manuals
 - f. Premium discount
2. Basic premium is less than standard premium. It is standard premium multiplied by a percentage called the basic premium factor. The basic premium factor varies depending on the total amount of standard premium.

The basic premium factor includes our general administration costs, related loss control service cost, and insurance charges.

The basic premium factor does not cover premium taxes or the portion of claims adjustment expenses that are accounted for in the loss conversion factor. Those elements are provided for in the tax multiplier and the loss conversion factor.

The Schedule shows a range of basic premium factors for differing amounts of estimated standard premium.

The actual basic premium factor will be determined after the standard premium is determined. If earned standard premium is not within the range of the estimated standard premiums shown in the Schedule, the basic premium will be recalculated.

3. Incurred losses are all amounts we pay or estimate we will pay for losses, interest on judgments, expenses to recover against third parties, and employers liability loss adjustment expenses. This includes paid and outstanding losses (including any reserves set on open claims).
 - a. Incurred losses do not include:



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

- (1) The cost in excess of the two most costly claims arising out of an accident involving two or more persons under a classification for which our manuals contain a non-ratable catastrophe surcharge required by our manuals.
 - (2) Losses involving passenger employees, other than members of the flying crew, if the losses result from the crash of an aircraft described on the Aircraft Premium Endorsement.
 - (3) Occupational disease losses for employers subject to the Federal Coal Mine Safety and Health Act
 - (4) Losses for acts of terrorism.
- b. If the Allocated Loss Adjustment Expense (ALAE) option is elected, this election will be shown in the Schedule and incurred losses will include ALAE. ALAE encompasses the following costs to us, which can be directly allocated to a particular claim:
- (1) Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside vendors or staff representatives
 - (2) Court, Alternate Dispute Resolution, and other specific items of expense such as:
 - (a) Medical examinations of a claimant to determine the extent of our liability, degree of permanency, or length of disability
 - (b) Expert medical or other testimony
 - (c) Autopsy
 - (d) Witnesses and summonses
 - (e) Copies of documents such as birth and death certificates, and medical treatment records
 - (f) Arbitration fees
 - (g) Surveillance
 - (h) Appeal bond costs and appeal filing fees
 - (3) Medical cost containment expenses incurred with respect to a particular claim, whether by an outside vendor or done internally by a staff representative for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include:
 - (a) Bill-auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, and medical or vocational rehabilitation vendor bills
 - (b) Hospital and other treatment utilization reviews, including precertification/preadmission, and concurrent or retrospective reviews
 - (c) Preferred provider network/organization expenses
 - (d) Medical fee review panel expenses
 - (4) Expenses that are not defined as losses and are directly related to and directly allocated to the handling of a particular claim for services that are required to be performed by statute or regulation.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

(5) Rehabilitation Costs

Voluntary vocational rehabilitation costs (e.g., medical care coordination costs over the limitation) must be reported as ALAE for injuries other than traumatic brain, spinal cord, amputation (including loss of eye(s)), and burns greater than 5% of the total body surface. Medical care coordination includes activities undertaken in order to assist in the containment of medical costs.

4. Converted incurred losses are based on the incurred losses for a policy or policies to which the retrospective rating plan applies. A loss conversion factor is applied to incurred losses to produce the converted incurred losses. The loss conversion factor is shown in the Schedule.
5. Taxes are a part of the premium we collect. Taxes are determined as a percentage of basic premium, converted incurred losses, and any elective elements. The percentage is called the tax multiplier. It varies by state and by federal and nonfederal classifications. The tax multiplier is shown in the Schedule.

B. Retrospective Rating Plan Premium Elective Elements

Two other elements are included in determining retrospective rating plan premium if you elected to include them. They are the excess loss premium for the loss limitation and the retrospective development premium. They are explained here.

1. The election of a loss limitation means that the amount of incurred loss to be included in the retrospective rating plan premium calculation is limited to an amount called the loss limitation. The loss limitation applies separately to each person who sustains bodily injury by disease and separately to all bodily injury arising out of any one accident.

The charge for this loss limitation is called the excess loss premium. Excess loss premium is a percentage of standard premium multiplied by the loss conversion factor. The percentage is called the excess loss premium factor.

Excess loss premium factors vary by state, by classification, and by the amount of the loss limitation. If you chose this elective element, the loss conversion factor, the loss limitation, and the excess loss premium factors are shown in the Schedule.

2. The retrospective development element is used to help stabilize premium adjustments. The premium for this element is charged with the first three calculations of a retrospective rating plan premium and is called the retrospective development premium. It is a percentage of standard premium multiplied by the loss conversion factor. The percentage of standard premium is called the retrospective development factor.

Retrospective development factors vary by state, by electing a loss limitation, and by first, second, and third calculations of retrospective rating plan premium. If you chose this elective element, the retrospective development factors are shown in the Schedule.

C. Retrospective Rating Plan Premium Formula

Workers compensation insurance policies listed in the Schedule will be combined with this policy to calculate the retrospective rating plan premium. If the policies provide insurance for more than one insured, the retrospective rating plan premium will be determined for all insureds who are eligible to be combined, not separately for each insured.

1. Retrospective rating plan premium is the sum of basic premium, converted losses and if elected, the excess loss premium and retrospective development premium. This sum is multiplied by the applicable tax multiplier shown in the Schedule.



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HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

2. The retrospective rating plan premium will not be less than the minimum or more than the maximum retrospective rating plan premium. The minimum and maximum retrospective rating plan premiums are determined by applying the minimum and maximum retrospective rating plan premium factors, shown in the Schedule, to the standard premium.
3. If this endorsement applies to more than one workers compensation policy, the standard premium will be the sum of the standard premiums for each workers compensation policy.

D. Calculation of Retrospective Rating Plan Premium

1. We will calculate the retrospective rating plan premium using all loss information we have as of a date six months after the policy period ends and annually thereafter.

We may make a special valuation of a retrospective rating plan premium as of any date that you are declared bankrupt or insolvent, make an assignment for the benefit of creditors, are involved in reorganization, receivership, or liquidation, or dispose of all your interest in work covered by the insurance. You will pay the amount due to us if the retrospective rating plan premium is more than the total standard premium as of the special valuation date.

2. After any calculation of retrospective rating plan premium, you and we may agree that it is the final calculation.
3. After each calculation of the retrospective rating plan premium, you will pay promptly the amount due us, or we will refund promptly the amount due you. Each insured is responsible for the payment of all standard premium and retrospective rating plan premium calculated under this endorsement.

E. Cancellation of a Policy Under a Retrospective Rating Plan

1. If the policy to which this endorsement is attached is cancelled, the effective date of the cancellation will become the end of the policy period for all the policies listed in the Schedule of this endorsement.
2. If any policies listed in the Schedule of this endorsement are cancelled, the effective date of cancellation will become the end of the policy period for all insurance subject to this endorsement unless we agree with you, by endorsement, to continue the policy period.
3. If we cancel for nonpayment of premium, the maximum retrospective rating plan premium will be based on the standard premium for the policy period, increased pro rata to 365 days, and will include all of the applicable retrospective rating plan factors shown in the Schedule.
4. If you cancel, the standard premium for the policy period will be increased by our short rate table and procedure. This short rate premium will be the minimum retrospective rating plan premium and will be used to determine the basic premium.

The short rate premium will be used to determine the excess loss premium and retrospective development premium if you chose these elective elements.

The maximum retrospective rating plan premium will be based on the standard premium for the policy period, increased pro rata to 365 days.

5. Section E.4. will not apply if you cancel because:
 - a. All work covered by the insurance is completed
 - b. All interest in the business covered by the insurance is sold
 - c. You retire from all business covered by the insurance



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HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

Schedule

1. Other workers compensation policies subject to this Retrospective Rating Plan Premium Endorsement
-
-

2. Loss Limitation: \$ 250,000

3. Loss Conversion Factor 1.059

4. Minimum Retrospective Rating Plan Premium Factor BXTM

Maximum Retrospective Rating Plan Premium Factor 5.000

5. The basic premium factors shown here are based on estimates of standard premium. If the actual standard premium is within the range of estimated standard premiums shown here, the basic premium factor will be obtained by linear interpolation to the nearest one-tenth of 1%. If the actual standard premium is not within the range of estimated standard premiums shown below, the basic premium factor will be recalculated.

	50%	100%	150%
Estimated Standard Premium:	<u>220,812</u>	<u>441,623</u>	<u>662,435</u>
Basic Premium Factor:	<u>0.160</u>	<u>0.143</u>	<u>0.140</u>

6. Incurred losses includes ALAE: yes X no



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ENDORSEMENT WC 09 05 03 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

7. The tax multiplier, excess loss premium factors, and retrospective development factors are shown in the Table of Additional Rating Factors.

TABLE OF ADDITIONAL RATING FACTORS

Excess Loss Premium Factors Federal Other than "F" Classes	("F" Classes Only)	Tax Multipliers		Retrospective Development Factors		
		Other than "F" Classes	Federal ("F" Classes Only)	1st	2nd	3rd
0.122		1.034				

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14 ST ASSIGN:

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ONE TOWER SQUARE
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WORKERS COMPENSATION
AND
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ENDORSEMENT WC 32 03 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

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



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ENDORSEMENT WC 32 03 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

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
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

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

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



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WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 01 (00) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

STATE	PERCENTAGE	STATE	PERCENTAGE
AZ	12.00	CA	100.00
CO	44.00	FL	141.00
GA	47.00	IL	38.00
KS	56.00	MO	45.00
NC	92.00	ND	76.00
NM	68.00	NV	23.00
OH	155.00	OR	98.00
TX	64.00	UT	61.00
WA	101.00	WY	161.00



ONE TOWER SQUARE
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WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 A1 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NOTICE OF CANCELLATION

Colorado Revised Statute 8-44-110 requires all insurance carriers to give a 30 day notice of cancellation, except in the case of: Fraud; Material Misrepresentation; Nonpayment of Premium; Other reasons approved by the Commissioner of Insurance.



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

**SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY**

The listed endorsements are only applicable in the following states:

WC 00 01 06 (A)-001 LONGSHORE AND HARBOR WC ACT COV ENDORSEMENT
APPLIES TO STATE(S): AZ CO FL GA IL KS MO NV NM NC OR TX UT
WC 00 01 14 (00)-001 CW NOTIFICATION ENDT OF PENDING LAW CHG TO TERRORI
APPLIES TO STATE(S): AZ CA CO GA IL KS MO NV NM NC OR UT
WC 00 03 03 (C)-001 CW EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
APPLIES TO STATE(S): AZ CO GA IL KS MO NV NM NC OR TX UT
WC 00 03 11 (A)-001 VOLUNTARY COMP AND EMPLOYERS LIAB COV ENDT
APPLIES TO STATE(S): AZ CO FL GA IL KS MO NV NM NC OR UT
WC 00 03 11 (00)-001 VOL COMP AND EMP LIAB COV END
APPLIES TO STATE(S): TX
WC 00 03 13 (00)-001 WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS
APPLIES TO STATE(S): AZ CO FL GA IL KS MO NV NM NC OR
WC 00 04 14 (00)-001 NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
APPLIES TO STATE(S): AZ CO FL GA IL KS MO NV NM NC OR UT
WC 00 04 19 (00)-001 MULTI-STATE PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S): CO FL GA IL KS MO NV NM NC UT
WC 00 04 21 (C)-001 CATASTROPHE (OTHER THAN CERT ACTS OF TERRORISM) PR
APPLIES TO STATE(S): AZ CA CO GA IL KS NV NC OR UT
WC 00 04 22 (A)-001 Terrorism-Reauthorization Act Disclosure
APPLIES TO STATE(S): AZ CA CO GA IL KS MO NV NM NC OR TX UT
WC 00 05 16 (00)-001 RETROSPECTIVE RATING PLAN PREMIUM ENDORSEMENT
APPLIES TO STATE(S): AZ CO GA IL KS MO NV NM NC OR TX UT
WC 02 04 01 (C)-001 ARIZONA ALCOHOL AND DRUG-FREE WORKPLACE PREM
APPLIES TO STATE(S): AZ
WC 02 06 01 (00)-001 ARIZONA CANCELATION ENDORSEMENT
APPLIES TO STATE(S): AZ
WC 04 01 01 (A)-001 LONGSHOREMEN'S & HARBOR WKRS' COMP ACT COV END-CA
APPLIES TO STATE(S): CA
WC 04 03 01 (B)-001 CA POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
APPLIES TO STATE(S): CA

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

SPECIAL PROVISIONS ENDORSEMENT STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 04 03 05 (00)-001 VOL COMP & EMPLOYERS LIAB COV ENDORSEMENT-CA
APPLIES TO STATE(S): CA
WC 04 03 17 (00)-001 CA ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING
APPLIES TO STATE(S): CA
WC 04 03 60 (A)-001 CA EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDT
APPLIES TO STATE(S): CA
WC 04 04 22 (00)-001 CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT
APPLIES TO STATE(S): CA
WC 04 06 01 (A)-001 CA CANCELATION ENDT
APPLIES TO STATE(S): CA
WC 05 04 02 (00)-001 COLORADO CLASSIFICATION ENDORSEMENT
APPLIES TO STATE(S): CO
WC 09 03 03 (00)-001 FL EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
APPLIES TO STATE(S): FL
WC 09 05 03 (00)-001 FLORIDA RETROSPECTIVE RATING PLAN PREMIUM ENDT
APPLIES TO STATE(S): FL
WC 09 06 06 (00)-001 FL EMPLOYMENT AND WAGE INFORMATION REL. ENDT.
APPLIES TO STATE(S): FL
WC 10 04 02 (00)-001 GA NON-COOPERATION WITH PREMIUM AUDIT ENDT
APPLIES TO STATE(S): GA
WC 10 06 01 (A)-001 GA CANC NONRENEWAL AND CHG ENDT
APPLIES TO STATE(S): GA
WC 12 06 01 (D)-001 IL ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): IL
WC 15 04 01 (A)-001 KANSAS FINAL PREMIUM ENDORSEMENT
APPLIES TO STATE(S): KS
WC 15 06 01 (A)-001 KANSAS CANCELATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): KS
WC 24 03 02 (00)-001 MO NOTIFICATION OF ADDL MESOTHELIOMA BENEFITS END
APPLIES TO STATE(S): MO
WC 24 04 06 (C)-001 MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT
APPLIES TO STATE(S): MO
WC 24 06 01 (B)-001 MO CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): MO
WC 24 06 02 (B)-001 MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOC.
APPLIES TO STATE(S): MO
WC 24 06 04 (A)-001 MISSOURI AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MO
WC 27 06 01 (C)-001 NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): NV
WC 30 03 01 (00)-001 NEW MEXICO SAFETY DEVICE COVERAGE ENDORSEMENT



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HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

SPECIAL PROVISIONS ENDORSEMENT STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S): NM
WC 30 04 01 (A)-001 NM WC PREM ADJ PROGRAM
APPLIES TO STATE(S): NM
WC 30 06 01 (00)-001 NM CANCELATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): NM
WC 32 03 01 (C)-001 NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT
APPLIES TO STATE(S): NC
WC 36 03 01 (00)-001 OREGON UNSAFE EQUIPMENT EXCLUSION ENDORSEMENT
APPLIES TO STATE(S): OR
WC 36 03 06 (00)-001 OREGON LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): OR
WC 36 04 06 (00)-001 OREGON PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S): OR
WC 36 06 01 (E)-001 OREGON CANCELLATION ENDORSEMENT
APPLIES TO STATE(S): OR
WC 36 06 02 (00)-001 OR OREGON CONFIDENTIALITY ENDORSEMENT
APPLIES TO STATE(S): OR
WC 42 01 01 (00)-001 TEXAS NOTIFICATION ENDORSEMENT OF PENDING LAW
APPLIES TO STATE(S): TX
WC 42 03 01 (F)-001 TX AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): TX
WC 42 03 04 (A)-001 TX WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS
APPLIES TO STATE(S): TX
WC 42 04 07 (00)-001 TX AUDIT PREMIUM AND RETROSPECTIVE PREMIUM
APPLIES TO STATE(S): TX
WC 43 03 05 (00)-001 UTAH WAIVER OF SUBROGATION ENDORSEMENT
APPLIES TO STATE(S): UT
WC 43 06 01 (00)-001 UT WORKPLACE SAFETY PROG ENDT
APPLIES TO STATE(S): UT
WC 43 06 02 (00)-001 UT CANCELLATION ENDORSEMENT
APPLIES TO STATE(S): UT
WC 99 01 01 (00)-001 STATE WC COMP LAWS AND USL & H WC ACT
APPLIES TO STATE(S): AZ CA CO FL GA IL KS MO NV NM NC OR UT
WC 99 01 19 (A)-001 TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION
APPLIES TO STATE(S):
WC 99 03 A1 (00)-001 CANC NOTICE ENDT-COLORADO
APPLIES TO STATE(S): CO
WC 99 03 C3 (00)-001 CA SPECIAL PROVISIONS ENDORSEMENT
APPLIES TO STATE(S): CA
WC 99 03 D3 (A)-001 OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
APPLIES TO STATE(S):



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

SPECIAL PROVISIONS ENDORSEMENT STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 99 03 F3 (00)-001 CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): CA
WC 99 03 76 (A)-001 WAIVER TO RECOVER ENDT - CA
APPLIES TO STATE(S): CA
WC 99 03 97 (00)-001 WYOMING AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):
WC 99 03 99 (00)-001 CA NOTICE OF NON-RENEWAL
APPLIES TO STATE(S): CA
WC 99 06 G8 (E)-001 FEDERAL TERRORISM RISK INSURANCE ACT DISCLOSURE
APPLIES TO STATE(S): AZ CA CO GA IL KS MO NV NM NC OR UT
WC 99 06 J6 (B)-001 FEDERAL TERRORISM RISK INS ACT DISCL - N.C.
APPLIES TO STATE(S): NC
WC 99 06 N1 (00)-001 FLORIDA TERRORISM RISK INSURANCE PROGRAM
APPLIES TO STATE(S): FL
WC 99 06 P7 (00)-001 NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSE
APPLIES TO STATE(S): CA OR
WC 99 06 P8 (00)-001 FLORIDA NOTICE OF CANCELLATION OR NONRENEWAL BY US
APPLIES TO STATE(S): FL
WC 99 06 Q1 (00)-001 EARLIER NOTICE OF CANCELLATION OR NONRENEWAL BY US
APPLIES TO STATE(S): CO IL TX UT
WC 99 06 Q2 (00)-001 MO EARLIER NOTICE OF CANCELLATION OR NONRENEWAL
APPLIES TO STATE(S): MO
WC 99 06 Q6 (00)-001 Ca Insurance Program Agreement
APPLIES TO STATE(S): CA
WC 99 06 03 (00)-001 GENERAL PURPOSE ENDORSEMENT
APPLIES TO STATE(S): AZ CA CO FL GA IL KS MO NV NM NC OR UT
WC 99 06 10 (A)-001 AMENDED CANCELLATION CONDITION
APPLIES TO STATE(S): GA KS NV NM
WC 99 06 10 (00)-001 AMENDED CANCELLATION CONDITION
APPLIES TO STATE(S): CO UT
WC 99 06 11 (A)-001 NOTICE OF CANCELLATION
APPLIES TO STATE(S): CA CO GA IL KS MO NV NM NC OR TX UT
WC 99 06 36 (A)-001 CANCELLATION AMENDMENT - WASHINGTON
APPLIES TO STATE(S):
WC 99 06 46 (00)-001 ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): IL
WC 99 06 47 (00)-001 CW AMENDED CANCELLATION CONDITION ENDORSEMENT
APPLIES TO STATE(S): NM
WC 99 06 99 (00)-001 ND AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in Ohio.

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

C. Exclusions

This insurance does not cover:

- 5. bodily injury directly intended by the insured;

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

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT

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

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

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

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

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 76 (A) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

Schedule

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 97 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

WYOMING AMENDATORY ENDORSEMENT

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

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

PART TWO – EMPLOYERS LIABILITY INSURANCE

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

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

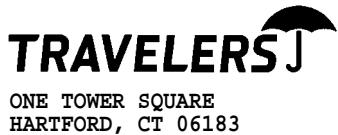
PART SIX – CONDITIONS

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

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. If the policy has been in effect for 60 days or more, or is a renewal of a previously existing policy for a term longer than 60 days, we may cancel only for one of the following reasons:
 - a. Failure to pay premium when due.
 - b. The policy was issued because of a material misrepresentation of fact.
 - c. There is a substantial change in the risk assumed, except to the extent that we should have reasonably foreseen or contemplated the change at the time that the policy was written.
 - d. There is a substantial breach of contractual duties, conditions or warranties.
3. We will deliver to you and your agent, or mail to you and your agent written notice of cancelation at your last known address. Proof of mailing shall be sufficient proof of notice.
4. If we cancel because you do not pay all premium when due, we will mail the notice of cancelation at least 10 days before the cancelation is to take effect. If we cancel for any other reason, except a material misrepresentation of fact, we will mail the notice of cancelation not less than 45 days before the cancelation is to take effect. Our notice will state the reasons for cancelation.

Nonrenewal

We may elect not to renew the policy. We will deliver to you and your agent, or mail to you and your agent, written notice at your last known address, not less than 45 days prior to the expiration of anniversary date of the policy. Our notice of nonrenewal will state the reasons for nonrenewal.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 03 99 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

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

2. We may cancel or not renew this policy by mailing or delivering to you written notice stating when such cancellation or nonrenewal is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. We will mail or deliver that notice:
 - a. At least ten days before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for nonpayment of premium; or
 - b. At least the number of days shown in the Schedule before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for any other reason.

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

SCHEDULE

NUMBER OF DAYS 60

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14 ST ASSIGN:

Page 1 of 1



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

FLORIDA NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

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

2. We may cancel or not renew this policy by mailing or delivering to you written notice stating when such cancellation or nonrenewal is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. We will mail or deliver that notice:
 - a. At least ten days before the effective date of the cancellation or nonrenewal, if we cancel or do not renew for nonpayment of premium; or
 - b. At least the number of days shown in the Schedule before the effective date of the cancellation or non-renewal, if we cancel or do not renew for any other reason.

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

SCHEDULE

NUMBER OF DAYS 60

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14 ST ASSIGN:

Page 1 of 1



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

EARLIER NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

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

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

SCHEDULE

NUMBER OF DAYS 60

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective
Insured

Policy No.

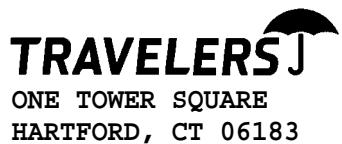
Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14 ST ASSIGN:

Page 1 of 1



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 99 06 Q2 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

MISSOURI EARLIER NOTICE OF CANCELLATION OR NONRENEWAL BY US ENDORSEMENT

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

If we cancel this policy and Missouri law requires us to give you at least 60 days advance notice of the cancellation, or if we do not renew this policy, we will increase the number of days advance notice for cancellation or nonrenewal from the required 60 days to the number of days shown in the Schedule.

SCHEDULE

NUMBER OF DAYS **60**

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: **04-15-14** ST ASSIGN:

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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 03 (00)- 01

POLICY NUMBER: (TRJUB-4246B09-2-14)

GENERAL PURPOSE ENDORSEMENT

LARGE RISK ALTERNATIVE RATING OPTION

IT IS HEREBY AGREED THAT THE INSURED AND THE INSURER HAVE
MUTUALLY AGREED TO A LARGE RISK ALTERNATIVE RATING OPTION
RETROSPECTIVE RATING PLAN.

IT IS APPLICABLE IN THOSE RETROSPECTIVE RATING STATES NOT
IDENTIFIED ON THE RETROSPECTIVE PREMIUM ENDORSEMENT.

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**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 06 10 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

AMENDED CANCELLATION CONDITION ENDORSEMENT

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

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

SCHEDULE

NUMBER OF DAYS

60



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 10 (00) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

AMENDED CANCELLATION CONDITION ENDORSEMENT

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

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

SCHEDULE

NUMBER OF DAYS

60



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 99 06 11 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NOTICE OF CANCELLATION

Except for non-payment of premium by you, we agree that no cancellation or limitation of this policy shall become effective until the number of day's written notice specified in item 2 of the Schedule has been mailed to you and to the person or organization designated in item 1 of the Schedule at the address indicated.

SCHEDULE

1. Name:

Address:

2. Number of Days Written Notice: 60 Additional Days

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 36 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

CANCELLATION AMENDMENT – WASHINGTON

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



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 99 06 99 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

This endorsement applies only to work in North Dakota.

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

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

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

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

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

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

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

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

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

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

You need not do anything further at this time.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 21 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14

ST ASSIGN:

Page 1 of 1



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 G8 (E)

POLICY NUMBER: (TRJUB-4246B09-2-14)

FEDERAL TERRORISM RISK INSURANCE ACT DISCLOSURE

This endorsement applies only to your Workers Compensation Benefit obligations.

On December 26, 2007, the President of the United States signed into law amendments to the Terrorism Risk Insurance Act of 2002 (the "Act"), which, among other things, extend the Act and expand its scope. The Act establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in the Act) caused by "acts of terrorism". An "act of terrorism" is defined in Section 102(l) of the Act to mean any act that is certified by the Secretary of the Treasury – in concurrence with the Secretary of State and the Attorney General of the United States – to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States Mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

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

Except as disclosed in state specific changes endorsements:

1.5% of your total Workers Compensation premium. Deductible and guaranteed cost policies (if any) will be subject to any applicable adjustments or audits. For retrospective policies (if any), the charge will be a flat charge which is charged at policy inception, not subject to any retrospective premium adjustments or audits.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 J6 (B)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**FEDERAL TERRORISM RISK INSURANCE ACT
DISCLOSURE – NORTH CAROLINA CHANGES**

This endorsement modifies insurance provided under your Workers Compensation Policy.

The final two (2) paragraphs of WC 99 06 G7, WC 99 06 G8, and WC 99 06 G9 are replaced by the following:

The charge for the terrorism coverage referenced in the Federal Terrorism Risk insurance Act Endorsement attached to the Policy does not apply to your North Carolina exposure. The rate used to develop your premium for your North Carolina exposure is \$0.01 per \$100 of North Carolina remuneration. This charge is included in the premium indicated in your policy. Deductible and guaranteed cost policies (if any) will be subject to any applicable adjustments or audits. For retrospective policies (if any), the charge will be a flat charge which is charged at policy inception, not subject to any retrospective premium adjustments or audits.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

TERRORISM RISK INSURANCE PROGRAM ENDORSEMENT

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

Definitions

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

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

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

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

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

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

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

Limitation of Liability

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

Policyholder Disclosure Notice

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE

PREMIUM

D. Premium is amended to read:

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



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 02 04 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**ARIZONA ALCOHOL – AND DRUG-FREE WORKPLACE PREMIUM
CREDIT ENDORSEMENT**

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

This endorsement provides notice that premium for your policy may be affected by the Arizona Alcohol-and Drug-Free Workplace Premium Credit Program.

You may qualify for a 5% premium credit if you have established and maintain a qualifying alcohol-and drug-free workplace program in accordance with Title 23, Chapter 2, Article 14 of Arizona Statutes.

We will determine your eligibility for this premium credit after total premium has been paid for the policy period and may be revised at the time your final premium audit is processed.

The determination that you have a qualifying program must be made each year that you receive the premium credit. To implement a premium credit program, the following guidelines must be established:

1. Insurers offering the premium credit program may apply a 5% premium credit to qualifying employers.
2. To receive the premium credit, you must:
 - a. Provide a written statement to the insurer prior to or within 30 days after the beginning of the policy effective date each year, certifying that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14.
 - b. At any time during the term of the policy, provide additional information to the insurer, as required, to confirm that a qualifying program has been established and is being maintained.
 - c. Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, Article 14.
 - d. Conduct alcohol and drug testing of prospective employees.
 - e. Conduct alcohol and drug testing of an employee after the employee has been injured.
 - f. Allow us to have access to the alcohol and drug testing results under d. and e. above.
3. The determination that you have established and maintain a qualifying program must be made during each policy term that you receive the premium credit.
4. Your certification and any other information relied upon by the insurer in granting the premium credit must be kept in the insurer's underwriting files and made available to the Department of Insurance upon request.
5. The premium credit may be applied after total premium has been paid for the policy period and may be revised at final audit to the employer's policy. The credit is applicable as a supplement to deviated rates and is applied in a multiplicative manner, after the application of the experience modification, and before the application of the premium discount and expense constant.



ONE TOWER SQUARE
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WORKERS COMPENSATION
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EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 04 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

6. You must reimburse the premium credit if it is determined that you were not in compliance with the provisions of the program.
7. Minimum premium policies are eligible for this premium credit.
8. Residual market employers are eligible to apply for this premium credit.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 06 01 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

ARIZONA CANCELATION ENDORSEMENT

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

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

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 if you fail to pay premium when due. We must mail or deliver to you and the Industrial Commission of Arizona not less than thirty 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.



ONE TOWER SQUARE
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WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 01 01 (A) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

C. Workers' Compensation Law

Workers' Compensation Law means the workers' or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers' or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

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

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

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

SCHEDULE

CODE NO.	CLASSIFICATION	ESTIMATED ANNUAL REMUNERATION	RATE PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
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SEE INFORMATION PAGE SCHEDULE(S)

Total Estimated Annual Premium \$



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

POLICY AMENDATORY ENDORSEMENT – CALIFORNIA

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

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

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

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

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

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

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



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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

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

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

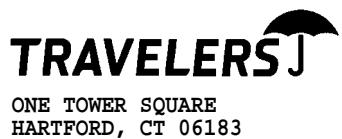
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective
Insured

Policy No.
Insurance Company

Endorsement No.

Countersigned by _____



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 04 03 05 (00) – 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

SCHEDULE

ALL EMPLOYEES NOT SUBJECT TO THE WORKERS' COMPENSATION LAW.



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT – CALIFORNIA

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

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

A. How This Insurance Applies

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

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

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

1. Exclusion 1 is amended to read as follows:

1. liability assumed under a contract.

2. Exclusion 2 is deleted.

3. Exclusion 7 is amended to read as follows:

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

4. The following exclusions are added:

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

CALIFORNIA SHORT-RATE CANCELLATION ENDORSEMENT

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

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

Short Rate Cancellation Table

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

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DATE OF ISSUE: 04-15-14

ST ASSIGN:

Page 3 of 3



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

CALIFORNIA CANCELLATION ENDORSEMENT

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

The cancellation condition in Part Six (Conditions) of the policy is replaced by these conditions:

CANCELLATION

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy for one or more of the following reasons:
 - a. Non-payment of premium;
 - b. Failure to report payroll;
 - c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
 - d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
 - e. Material misrepresentation made by you or your agent;
 - f. Failure to cooperate with us in the investigation of a claim;
 - g. Failure to comply with Federal or State safety orders;
 - h. Failure to comply with written recommendations of our designated loss control representatives;
 - i. The occurrence of a material change in the ownership of your business;
 - j. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
 - k. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
 - l. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Items (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of cancellation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
4. The policy period will end on the day and hour stated in the cancellation notice.



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 05 04 02 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

COLORADO CLASSIFICATION ENDORSEMENT

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

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassification was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph:

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

- C.** Exclusion 5, Section C. of Part Two of the policy, is replaced by the following:
- This insurance does not cover
5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

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

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 10 04 02 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

GEORGIA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 10 06 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

GEORGIA CANCELATION, NONRENEWAL AND CHANGE ENDORSEMENT

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

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

D. Cancelation, Nonrenewal and Change

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect, subject to the following:
 - a. If only your interest is affected, the effective date of cancelation will be the later of the date we receive notice from you or the date specified in the notice.
 - b. If by statute, regulation or contract this policy may not be canceled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days notice to you and the third party as soon as practicable after receiving your request for cancelation.

Our notice will state the effective date of cancelation, which will be the later of the following:

- 1) 10 days from the date of mailing or delivering our notice, or
- 2) The effective date of cancelation stated in your notice to us.

2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancelation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium or if we nonrenew this policy, we must send to you a notice of cancelation or nonrenewal by certified mail, return receipt requested, to your last address of record at least 75 days prior to the effective date of cancelation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase due to change in risk, exposure or experience modification or resulting from an audit or auditable coverages), limit or restrict coverage, we must mail by first class mail or deliver a notice of our action (including dollar amount of any increase in renewal premium more than 15%) to you at the last mailing address of record at least 45 days before the expiration date of this policy.
4. The policy period will end on the day and hour stated in the cancelation notice except as provided for above.



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

ILLINOIS AMENDATORY ENDORSEMENT

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

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

Inspection

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

Cancellation

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

Nonrenewal

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

Sole Representative

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

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

Audit

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

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned By _____

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DATE OF ISSUE: 04-15-14

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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 15 04 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

KANSAS FINAL PREMIUM ENDORSEMENT

This endorsement changes how the final premium is determined. The change applies only to the premium charged because Kansas is shown in Item 3.A. of the Information Page

- Kansas final premium will not be less than the highest minimum premium for the classifications covered by this policy unless there are two or more classifications covered and the highest rated classification has less than \$500 payroll.
- When this occurs the final premium will not be less than one-half of the sum of the two highest minimum premiums for any classifications covered by the policy other than Clerical Office and Salespersons.
- When the highest rated classification has less than \$500 payroll and Standard Exception classifications are the only classifications showing payrolls, the final premium will not be less than the minimum premium for the classification showing the highest payroll.
- Final premium for a multiple state policy will be that of the state with the single highest minimum premium, even if that state is on an "if any" basis. If two or more states have the same highest minimum premium, the minimum premium is determined by the state with the largest amount of standard premium.
- Minimum premium is subject to final adjustment at audit and will be determined only on the basis of the classifications developing premium.
- If the final earned premium is less than the minimum premium determined at audit, then that minimum premium must be charged.
- If no classification develops premium, the final premium shall be a flat charge of \$200.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 15 06 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

KANSAS CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Condition of the policy is replaced by these two Conditions:

Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. If we cancel because you fail to pay all premium when due, we will mail or deliver to you not less than 10 days advance written notice stating when the cancellation is to take effect. If we cancel for any other reason, we will mail or deliver to you not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.
3. If this policy has been in effect for 90 days or more, we may cancel only for one of the following reasons:
 - a. nonpayment of premium;
 - b. the policy was issued because of a material misrepresentation;
 - c. you violated any of the material terms and conditions of the policy;
 - d. there are unfavorable underwriting factors, specific to you, that were not present when the policy took effect;
 - e. the Commissioner has determined that our continuation of coverage could place us in a hazardous financial condition or in violation of the laws of Kansas; or
 - f. the Commissioner has determined that we no longer have adequate reinsurance to meet our needs.
4. Our notice of cancellation will state our reasons for canceling.
5. The policy period will end on the day and hour stated in the cancellation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice when the nonrenewal will take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
2. Our notice of nonrenewal will state our reasons for not renewing.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 24 03 02 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

MISSOURI NOTIFICATION OF ADDITIONAL MESOTHELIOMA BENEFITS ENDORSEMENT

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

Section 287.200.4, subdivision (3), of the Missouri Revised Statutes provides additional benefits in the case of occupational diseases due to toxic exposure that are diagnosed to be mesothelioma and result in permanent total disability or death. Your policy provides insurance for these additional benefits.

If you reject liability for mesothelioma additional benefits provided under Section 287.200.4, subdivision (3), of the Missouri Revised Statutes, you must notify us of this election. Once you notify us, we will endorse this policy to exclude insurance for these additional benefits. If you reject liability for mesothelioma additional benefits, the exclusive remedy provisions under Missouri Revised Statutes Section 287.120 shall not apply to your liability for mesothelioma additional benefits.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14

ST ASSIGN:

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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 06 01 (B)

POLICY NUMBER: (TRJUB-4246B09-2-14)

MISSOURI CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will mail or deliver to you not less than 60 days advance written notice stating when the cancelation is to take effect and our reason for cancelation. Proof of mailing of this notice to you at your mailing address shown in item 1 of the Information Page will be sufficient to prove notice.
3. The 60-day notice requirement does not apply where cancelation is based on one or more of the following reasons:
 - a. nonpayment of premium
 - b. fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;
 - c. a violation of policy terms;
 - d. changes in conditions after the effective date of the policy materially increasing the hazards originally insured;
 - e. our insolvency;
 - f. our involuntary loss of reinsurance for the policy.
4. The policy period will end on the day and hour stated in the cancelation notice

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice stating when the nonrenewal will take effect and our reason for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in item 1 of the Information Page will be sufficient to prove notice.
2. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
 - a. we show you our willingness to renew the policy but you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
 - b. you fail to pay all premiums when due; or
 - c. you obtain other insurance as a replacement of the policy.



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 24 06 02 (B)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOCIATION
NOTIFICATION ENDORSEMENT**

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

Missouri Property and Casualty Insurance Guaranty Association Coverage Limits:

1. Subject to the provisions of the Missouri Property and Casualty Insurance Guaranty Association Act (Act), if we are a member of the Missouri Property and Casualty Insurance Guaranty Association (Association), the Association will pay claims covered under the Act if we become insolvent.
2. The Act contains various exclusions, conditions and limitations that govern a claimant's eligibility to collect payment from the Association and affect the amount of any payment. The following limitation applies subject to all other provisions of the Act:
 - a. Claims covered by the Association do not include a claim by or against an insured of an insolvent insurer if the insured has a net worth of more than \$25 million on the later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis.

If the insured prepares an annual report to shareholders, or an annual report to management reflecting net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurer will be used to determine net worth.

However, the association will not:

- (1) Pay an amount in excess of the applicable limit of insurance of the policy from which a claim arises; or
- (2) Return to an insured any unearned premium in excess of \$25,000.

These limitations have no effect on the coverage we will provide under this policy.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium

Insurance Company

Countersigned by _____

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DATE OF ISSUE: 04-15-14

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ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

MISSOURI AMENDATORY ENDORSEMENT

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

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

G. Audit

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

Audits shall be completed, billed, and premiums returned within 120 days of policy expiration or cancellation. This standard of 120 days shall not be applicable if:

1. A delay is caused by your failure to respond to reasonable audit requests provided that the requests are timely and adequately documented; or
2. A delay is by the mutual agreement of you and us provided that the agreement is adequately documented.

If you or we have any objection to the results of any audit, you or we shall have up to three years from the date of expiration or cancellation of this policy in which to send a written notice demanding a reconsideration of the audit. The written notice shall be based upon sufficiently clear and specific facts as to why the audit should be reconsidered.

If you do not allow us to examine and audit all of your records that relate to this policy or do not provide audit information as reasonably requested, we may apply an Audit Noncompliance Charge equal to estimated annual premium.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, your premium will be revised accordingly.

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

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium

Insurance Company

Countersigned by _____

DATE OF ISSUE: 04-15-14

ST ASSIGN:

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ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 27 06 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Part Six – Conditions, D. Cancellation of the policy is replaced by the following:

A. Midterm Cancellation

1. You may cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect.
2. We will provide you not less than 10 days notice if this policy is cancelled because you failed to pay a premium or remit an amount due because of an endorsement for a deductible when due.
3. We will provide you not less than 30 days notice for any other cancellation reason permitted under Nevada law, including failure to pay additional premium charged due to an audit of any payroll under the terms of the current or previous policy.
4. No policy of industrial insurance that has been in effect for at least 70 days or that has been renewed may be cancelled, except on any one of the following grounds:
 - a. A failure by the policyholder to pay a premium for the policy of industrial insurance when due, including the failure of the policyholder to remit an amount due because of an endorsement for a deductible;
 - b. A failure by the policyholder to:
 - (1) Report any payroll;
 - (2) Allow the insurer to audit any payroll in accordance with the terms of the policy or any previous policy issued by the insurer; or
 - (3) Pay any additional premium charged because of an audit of any payroll as required by the terms of the policy or any previous policy issued by the insurer;
 - c. A material failure by the policyholder to comply with any federal or state order concerning safety or any written recommendation of the insurer's designated representative for loss prevention;
 - d. A material change in ownership of the policyholder or any change in the policyholder's business or operations that:
 - (1) Materially increases the hazard for frequency or severity of loss;
 - (2) Requires additional or different classifications for the calculation of premiums; or
 - (3) Contemplates an activity that is excluded by any reinsurance treaty of the insurer;
 - e. A material misrepresentation made by the policyholder; or
 - f. A failure by the policyholder to cooperate with the insurer in conducting an investigation of a claim.
5. We cannot cancel the policy when the referenced reasons are corrected by you within the time specified in the written notice of cancellation.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 27 06 01 (C)

POLICY NUMBER: (TRJUB-4246B09-2-14)

B. Nonrenewal

1. We may elect not to renew the policy. We will provide to you a written notice of our intention not to renew at least 60 days before the expiration date.
2. We need not provide notice of our intention not to renew if you have accepted replacement coverage, if you have requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

C. Information About Claims Paid

1. If you request information for the renewal of the policy, we will provide you with information regarding claims paid on your behalf.
2. We will provide the information within 30 working days after we receive your written request. We may charge a reasonable fee for providing the information.

D. Notices

1. We will provide advance written notice of cancellation or nonrenewal as provided in A and B above. This notice must be served personally on or sent by first-class mail or electronic transmission to the employer.
2. Notices will state the effective date of the cancellation or nonrenewal and will be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal.
3. A written notice of cancellation is not required if we mutually agree with you to cancel the policy and reissue a new policy based upon a material change in the ownership or operation of your business.

E. Compliance With Law

1. Any of these provisions that conflict with a law that controls the cancellation or renewal or nonrenewal of the insurance in this policy is changed by this statement to comply with the law.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 30 03 01 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NEW MEXICO SAFETY DEVICE COVERAGE ENDORSEMENT

Section 52-1-10 of the New Mexico workers compensation law may make you liable for the payment of additional benefits in the case of bodily injury to employees resulting from your failure to supply safety devices. The benefits payable under Part One (Workers Compensation Insurance) includes these additional benefits.



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 30 04 01 (A)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**NEW MEXICO WORKERS COMPENSATION PREMIUM ADJUSTMENT
PROGRAM FOR QUALIFYING CLASSIFICATIONS ENDORSEMENT**

The premium for the policy may be adjusted by New Mexico Workers Compensation Premium Adjustment credits and Offset to Experience Rating debit. The credits and debit were not available when the policy was issued. If you qualify, or if estimated credits and estimated debit have been applied, we will issue an endorsement to show the proper premium adjustment credits and debit after they are calculated.



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 30 06 01 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

NEW MEXICO CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

You may cancel this policy by returning it to us or by giving us a written notice and stating at what future time coverage is to cease. We may cancel this policy, or one or more of its parts, by giving you a written notice. If the premium has not been paid when due, we may cancel at any time by giving the required notice at least 10 days before the cancelation is effective.

If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel by giving the required notice at least 10 days before the cancelation is effective.

If the policy has been in effect for 60 days or more or is a renewal, we may cancel only for one or more of the following reasons:

- a. The policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by us;
- b. Willful and negligent acts or omissions by the insured have substantially increased the hazards insured against; to the acceptance of the risk or to the hazard assumed by us;
- c. You presented a claim based on fraud or material misrepresentation; or
- d. There has been a substantial change in the risk assumed by us since the policy was issued.

We will give the required Notice of Cancelation stating the reason(s) for cancelation at least 30 days before the cancelation is effective. The notice will state the time that the cancelation is to take effect. The notice will be sent to your mailing address last known to us. Your return premium, if any, will be calculated as follows:

- a. If we cancel, we will return all unearned premiums.
- b. If you cancel, the refund will be calculated according to our rules.

Your return premium will be refunded to you with the cancelation notice or within a reasonable time. Payment or tender of the unearned premium is not a condition of cancelation.

Nonrenewal

If we decide not to renew this policy, we must give you written notice of our intention not less than 30 days prior to the expiration of the policy. This nonrenewal section does not apply to any policy of insurance issued to an insured who has its principal place of business outside this state.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 03 01 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

OREGON UNSAFE EQUIPMENT EXCLUSION ENDORSEMENT

Part Two (Employers Liability Insurance) does not cover bodily injury arising out of your failure to comply with a notice posted pursuant to ORS 654.082 of the Oregon Safe Employment Act or any amendment to that Act.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 36 04 06 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

OREGON 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 specified in the billing invoice for the policy.**



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 01 (E)

POLICY NUMBER: (TRJUB-4246B09-2-14)

OREGON CANCELLATION ENDORSEMENT

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

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

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us, starting when the cancellation is to take effect. If you provide for other insurance or self-insurance, your cancellation of coverage will take effect upon the effective date of that insurance.
2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.
 - a. If we cancel based on our decision not to offer insurance to all employers with in your premium category, we will mail the notice of cancellation at least 90 days before the cancellation is to take effect.
 - b. If we cancel for other reasons, we will mail the notice of cancellation at least 45 days before the cancellation is to take effect.
 - c. If we cancel for nonpayment, we will mail notice of cancellation at least 10 days before the cancellation to take effect.
3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.
4. The policy period will end at 12 midnight on the day stated in the cancellation notice.
5. When coverage is placed with another carrier as of the policy expiration date, a rejected renewal policy shall be withdrawn without charge, provided notice of nonrenewal is mailed and postmarked on or before the expiration date and is received from the insured by the insurer no later than 10 calendar days after said expiration date.

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

B. Who Is Insured is amended to read:

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

D. State is amended to read:

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

PART ONE-WORKERS COMPENSATION INSURANCE

E. Other Insurance is amended by adding this sentence:

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

F. Payments You Must Make

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

H. Statutory Provisions

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

PART TWO-EMPLOYERS LIABILITY INSURANCE

C. Exclusions

Sections 2 and 3 are amended to add:

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

Section 6 is amended to read:

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

D. We Will Defend

This Section is amended by deleting the last sentence.

PART FOUR-YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

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

PART FIVE-PREMIUM

A. Our Manuals is amended by adding this sentence:

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

C. Remuneration

Number 2 is amended to read:

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

E. Final Premium

Number 2 is amended to read:

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

PART SIX-CONDITIONS

A. Inspection is amended by adding this sentence:

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

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

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

D. Cancellation is amended to read:

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

PART SEVEN-OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. Claims Notification

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

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

COMPLAINT NOTICE: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 42 03 04 (A) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

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

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

The premium for this endorsement is shown in the Schedule.

Schedule

1. Specific Waiver

Name of person or organization

Blanket Waiver

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

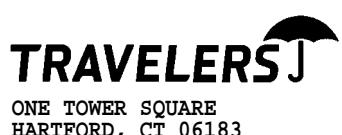
2. Operations:

ALL TEXAS OPERATIONS

3. Premium:

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

4. Advance Premium: \$ **SEE SCHEDULE**



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

POLICY NUMBER: (TRJUB-4246B09-2-14)

TEXAS—AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

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

PART FIVE—PREMIUM

D. Premium Payments

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

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 43 03 05 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

UTAH WAIVER OF SUBROGATION ENDORSEMENT

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

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

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule. Our waiver of rights does not release your employees' rights against third parties and does not release our authority as trustee of claims against third parties.

Schedule

Designated Person:

Designated Organization:

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



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 43 06 01 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

UTAH WORKPLACE SAFETY PROGRAM ENDORSEMENT

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

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

You may be required to establish such a program if:

1. You have an experience modification factor of 1.00 or higher as determined by NCCI; or
2. You have a three year loss ratio of 100% or higher.

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

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

SCHEDULE

0.00



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 43 06 02 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

UTAH CANCELLATION ENDORSEMENT

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

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

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. If this policy has been previously renewed or has been in effect for at least 60 days, the provisions of this paragraph 2 apply. We may cancel this policy for one of the following reasons:
 - a. You fail to pay all premiums when due;
 - b. A material misrepresentation;
 - c. A substantial change in the risk assumed, unless we should reasonably have foreseen the change or contemplated the risk when entering into the contract;
 - d. Substantial breaches of contractual duties, conditions or warranties.

We will mail or deliver to you not less than 30-days advance written notice stating when the cancellation is to take effect, except in the event you fail to pay your premiums when due, in which case we will mail or deliver to you not less than 10-days advance written notice stating when the cancellation is to take effect. Should we cancel for non-payment of premiums, we must state this as the reason for the cancellation on our notice of cancellation. Should we cancel for any of the other reasons above, we must either state the facts on which our decision is based or notify you of your right to make a written request for that information. Mailing a cancellation notice via first class mail to you at your mailing address last known to us will be sufficient to prove notice.

3. If this policy has not previously been renewed and has been in effect less than 60 days, we may cancel the policy for any reason and without a statement of reasons. We will deliver to you not less than 10-days advance written notice stating when the cancellation is to take effect.
4. The policy period will end on the day and hour stated in the cancellation notice.

B. Renewal/Nonrenewal

1. You have the right to have the insurance renewed unless:
 - a. The policy has been cancelled;
 - b. The policy is expressly designated as nonrenewable;
 - c. You fail to pay the renewal premium by the due date. We will mail the renewal notice to you not more than 45 days nor less than 14 days prior to the renewal effective date. The renewal notice will include the estimated renewal premium, how it may be paid, and state that failure to pay the renewal premium by the due date extinguishes your right to the renewal; or
 - d. We give you 30-days notice of nonrenewal prior to the expiration or the anniversary date. We must deliver or send the notice by first class mail to your last known mailing address.
2. If we offer to renew the policy but on less favorable terms or at higher rates, the new terms or rates will take effect on the renewal date if we delivered or sent by first class mail to you notice of the new terms or rates at least 30 days prior of the expiration date of the prior policy. The prior notice requirement does not



ONE TOWER SQUARE
HARTFORD, CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 43 06 02 (00)**

POLICY NUMBER: (TRJUB-4246B09-2-14)

apply if the only change is a rate increase generally applicable to your class of business, a rate increase resulting from a classification change, or a policy form change made to make the form consistent with Utah law.

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 N1 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

**FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION
ACT ENDORSEMENT – Retrospective Plans**

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

Definitions

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

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

Limitation of Liability

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



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 N1 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

Policyholder Disclosure Notice

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

Schedule

\$0.02 per \$100 of Remuneration

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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

ILLINOIS AMENDATORY ENDORSEMENT

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

C. Exclusions

1. is replaced by:

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

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



ONE TOWER SQUARE
HARTFORD, CT 06183

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

POLICY NUMBER: (TRJUB-4246B09-2-14)

AMENDED CANCELLATION CONDITION ENDORSEMENT

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

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

SCHEDULE

NUMBER OF DAYS

60

Insurance Program Agreement

For

GARDEN FRESH RESTAURANT CORP

Period:

April 01, 2014 to April 01, 2015



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This Agreement is made as of the Program Effective Date, referenced on the Program Summary, between the Named Insured referenced on the Program Summary and The Travelers Indemnity Company and such other company(ies) issuing any of the Policies listed in the Policy Exhibit ("Policy(ies)") attached hereto and incorporated herein by reference. As used in this Agreement the words "we", "us", "our" and "Travelers" mean The Travelers Indemnity Company and each of its property casualty insurance and service subsidiaries and affiliates, but only to the extent such companies have issued Policies or are performing services for you under this Agreement, as well as St. Paul Fire and Marine Insurance Company and each of its property casualty insurance subsidiaries and affiliates, but only to the extent such companies have issued Policies or are performing services for you under this Agreement. The words "you" and "your" mean and include the Named Insured referenced on the Program Summary and each of its predecessors and successors and each of its affiliates, divisions, subsidiaries, general partners and/or limited partners who are named insureds on any of the Policies and with respect to workers compensation insurance, who are employers referenced in Item 1. of the Information Pages of the workers compensation Policies.

If you request and we agree that Collateral to secure all or a portion of your Obligations will be provided by one of your successors, or by one of your affiliates, divisions or subsidiaries which is a named insured on any of the Policies listed on the Policy Exhibit of this Agreement, any past Agreements or any renewal Agreements or Amendments, and the Collateral is in fact so provided, you agree that the entity providing the Collateral is bound by all of the terms and conditions of this Agreement, including but not limited to the provisions that the Collateral provided secures all Obligations under this Agreement and under all of the Policies (regardless of the amount of Collateral provided by that entity) and that the duties and Obligations of that entity and you and your other successors and affiliates, divisions and subsidiaries are joint and several.

You agree that your duties and Obligations are joint and several in nature. "The parties" refers to you and us collectively. This Agreement represents the agreement the parties have reached whereby we will provide to you certain insurance coverages and services for the Policies we have issued pursuant to this Agreement, which Policies are incorporated herein by reference, in consideration of your payment of the Obligations described in the Sections and Exhibits comprising this Agreement.

In consideration of the mutual promises contained in this Agreement, the parties agree as follows:

DEFINITIONS SECTION

In addition to the terms defined in the preceding paragraphs, the following terms have special meaning in this Agreement. All defined terms should be equally applicable to both the singular and plural.

"Allocated Loss Adjustment Expense" or "ALAE" has the same meaning as "Allocated Loss Adjustment Expense" or "ALAE" or "claim expense" in the applicable Policy or, if the Policy contains no such definition, means the following costs which can be directly allocated to a particular claim:

1. Fees of attorneys or other authorized representatives where permitted for legal services, whether by outside or staff representatives.
2. Court, Alternate Dispute Resolution and other specific items of expense whether incurred by an outside vendor or by one of our employees, including but not limited to:
 - Medical examinations of a claimant to determine the extent of our liability, degree of permanency or length of disability;
 - Expert medical or other testimony;
 - Autopsy;
 - Witnesses and summonses;
 - Copies of documents such as birth and death certificates and medical treatment records;
 - Arbitration fees;

- Fees or costs for surveillance or other professional investigations which are conducted as part of the handling of a Claim;
 - Fees or costs for Risk Control personnel and fees or costs for rehabilitation nurses or other nurses, if the cost of such nurses is not included in losses, for services which are conducted as part of the handling of a Claim;
 - Appeal bond costs and appeal filing fees;
 - All reasonable expenses incurred by you in the investigation or defense of a Claim.
3. Medical cost containment expenses incurred with respect to a particular Claim, whether by an outside vendor or done internally by an employee for the purpose of controlling losses, to ensure that only reasonable and necessary costs of services are paid. The expenses include but are not limited to:
- Bill auditing expenses for any medical or vocational services rendered, including hospital bills (inpatient or outpatient), nursing home bills, physician bills, chiropractic bills, medical equipment charges, pharmacy charges, physical therapy bills, medical or vocational rehabilitation vendor bills.
 - Hospital and other treatment utilization reviews, including pre-certification/pre-admission, concurrent or retrospective reviews.
 - Preferred Provider Network/Organization expenses.
 - Medical fee review panel expenses.
4. Expense(s) not defined as losses which are directly related to and directly allocated to the handling of a particular Claim and are required to be performed by statute or regulation.
5. Supplementary Payments, as defined in those Policies which have a Supplementary Payments provision, except for salaries, overhead and traveling expenses of carrier employees who are not doing activities previously listed as allocated expenses.
6. Defense Costs, as defined in those Policies which have a Defense Cost provision, except for salaries, overhead and traveling expense of carrier employees who are not doing activities previously listed as allocated expenses.

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

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

"Claim" shall be any request or demand for consideration of payment or investigation of an Incurred Loss with respect to the Policies.

"Collateral" means security for your Obligations which you are required to provide to us pursuant to this Agreement and which is acceptable to us in form, content, issuer and amount.

"Maximum Loss Content" is, subject to the formula listed in the Maximum Loss Content and Minimum Program Cost part of the Program Summary, the most we will charge you for losses listed therein. Claims Handling Charges and Premium Tax associated with these losses are not part of the Maximum Loss Content and will continue to be billed and payable until the Maximum Loss Content is reached. Surcharges and

Assessments associated with these losses are not part of the Maximum Loss Content but will continue to be billed and payable after the Maximum Loss Content is reached.

"Minimum Program Cost" is, subject to the formula listed in the Maximum Loss Content and Minimum Program Cost part of the Program Summary, the least we will charge you for the Policies.

"Modified Tariff Premium" is, for the purpose of calculating your surcharge and assessment liability, manual premium after application of experience modification.

"Modified Discounted Tariff Premium" is, for the purpose of calculating your surcharge and assessment liability, manual premium after application of experience modification and premium discount.

"Obligations" means any indebtedness or liability of any kind owed or owing by you to us, whether direct or indirect, joint or several, now existing or hereafter arising in connection with this Agreement, the Policies, any past or future agreement letters or insurance program agreements, any agreements incorporated herein by reference, and any other similar agreements, including, but not limited to, any indemnity or self-funded retention agreements between you and United States Fidelity and Guaranty Company, Discover Property & Casualty Insurance Company or any of our other affiliates, and all costs and expenses, including, but not limited to, attorneys' fees incurred by us in enforcing your Obligations to us.

"Retrospective Plan Basic Premium" or **"Basic Premium"** is the amount we charge for our expenses for Policies subject to a Retrospective Plan.

"Retrospective Plan Incurred Loss" or **"Incurred Loss"** means all losses actually paid and the reserves for unpaid losses as estimated by us attributed to the Retrospective Plan Policies. For each line of insurance, the Amounts Retained By You part of the Program Summary denotes whether Allocated Loss Adjustment Expense is included in or is in addition to Retrospective Plan Incurred Loss.

"Retrospective Plan Paid Loss" or **"Paid Loss"** means losses actually paid by us within the Retrospective Plan Loss Limitation attributed to the Retrospective Plan Policies. For each line of insurance, the Amounts Retained By You part of the Program Summary denotes whether Allocated Loss Adjustment Expense is included in or is in addition to Retrospective Plan Paid Loss.

"Written Premium" is, for the purpose of calculating your surcharge and assessment liability, earned loss responsive premium plus Non-Loss Responsive Premium for Workers Compensation & Employers Liability, until the Final Retrospective Plan Adjustment Date(s) set forth in the Retrospective Plan RDF part(s) of the Program Summary. On the Final Retrospective Plan Adjustment Date(s), Written Premium will include that portion of the Final Retrospective Plan Premium Adjustment Amount applicable to the state.

RATING PLAN(S) COMPUTATION SECTION

Certain of your Policies are subject to a Retrospective Plan. This Section describes certain additional Obligations, terms and conditions associated with such Policies. We issue such Policy(ies) based upon your compliance with the terms and conditions set forth in this Section. All formulas, capitalized terms, rates, exposure bases, and charges associated therewith which are referenced in the following subsections are set forth in the applicable part of the Program Summary.

A. Retrospective Plan Computation

The total Retrospective Plan premium for the retrospectively rated Policies shall be calculated using the Retrospective Plan Computation Formula, which is subject to the following additional terms, conditions, limitations, adjustments and rates:

1. Retrospective Plan Incurred Losses

Retrospective Plan Incurred Losses are subject to the Retrospective Plan Loss Limitation(s) as set forth in the Amounts Retained By You part of the Program Summary.

2. Retrospective Plan Claims Handling Charges

Your Retrospective Plan Claims Handling Charges are set forth in the Claim Handling Charges part of the Program Summary.

3. Basic Premium

Your Basic Premium is the amount determined by the application of your Basic Premium formula. In no event will your Basic Premium be less than the Minimum Basic Premium as set forth in the applicable part of the Program Summary.

4. Calculation of Retrospective Plan Premium

Your Retrospective Plan Premium will be calculated based upon your total Incurred Losses. The exact nature of how you must pay is set forth in the Payment Section.

5. Premium Tax

You will pay premium tax in accordance with individual state requirements.

Your premium tax amounts will include any residual market charges which may be assessed by or in the various states.

Your premium tax rate is applicable to all the component parts of the Retrospective Plan Computation Formula. Your premium tax rate is set forth in the Premium Tax Rates part of the Program Summary. Your premium tax is payable and adjusted in accordance with the Payment Section.

6. Retrospective Plan Premium Adjustments

Each Retrospective Plan Premium Adjustment Amount (including the Final Retrospective Plan Premium Adjustment Amount) is calculated pursuant to the Retrospective Plan RDF part of the Program Summary. Also, there is premium tax associated with each Retrospective Plan Premium Adjustment which premium tax will be calculated by multiplying each Retrospective Plan Premium Adjustment Amount times the tax rate(s) set forth in the Premium Tax Rates part of the Program Summary. You will be responsible for paying this premium tax amount in addition to each Retrospective Plan Premium Adjustment Amount.

B. Maximum Loss Content and Minimum Program Cost

Your estimated Maximum Loss Content, and rating plan components subject to your Maximum Loss Content, are stated in the Maximum Loss Content and Minimum Program Cost part of the Program Summary. These amounts will be calculated using the Maximum Loss Content Formula as set forth in the Maximum Loss Content and Minimum Program Cost part of the Program Summary.

Your estimated Minimum Program Cost, and rating plan components subject to your Minimum Program Cost, are stated in the Maximum Loss Content and Minimum Program Cost part of the Program Summary. Your Minimum Program Cost is a flat charge in the amount set forth in the Maximum Loss Content and Minimum Program Cost part of the Program Summary.

C. Audit(s)

We will adjust or audit your records on either a physical or statement basis, at our option or as required by law, to determine your actual exposure base and calculate those charges on the Program Summary which are subject to audit. In no event will any of those charges be less than any applicable minimums set forth in the Program Summary. That amount, and the exact nature of how you must pay, is set forth in the Payment Section.

D. Medical Cost Containment Expense Component of ALAE

The pricing structure for this component of your program is set forth in the Medical Cost Containment Expense Component of ALAE Exhibit attached to this Agreement and incorporated herein by reference.

PAYMENT SECTION

This Section sets forth the manner in which certain of your Obligations will be paid. All of the dates and frequencies referenced herein are set forth in the Key Dates part of the Program Summary. The parties have agreed that these Obligations will be paid as follows:

A. Installments

You will pay to us the Installment amounts as set forth in the Installment Schedule part of the Program Summary.

You will pay any additional amount or we will credit any overpayment of the aforesaid charges as may be subsequently determined by audit and/or other adjustment at the time of such audit and/or other adjustment as provided for in this Agreement.

B. Plan Adjustments

1. Retrospective Plan Premium Adjustment

As of the Retrospective Plan Premium Adjustment date shown in the Key Dates part of the Program Summary until the Final Retrospective Plan Premium Adjustment as set forth in the Retrospective Plan RDF part of the Program Summary, we will compare the amounts due under the Retrospective Plan Computation Formula of this Agreement with the amounts paid.

The calculation of Retrospective Plan Premium shall always be subject to your Minimum Program Cost and Minimum Maximum Loss Content as set forth in the Program Summary and General Conditions Section.

2. Applicable to All Adjustments

For all the aforementioned plan adjustments, we will either return or credit against other sums due from you any overpayments of such amounts or bill you for any deficiencies in such payments. Any such plan adjustment bill shall be payable as indicated on our invoice to you. In the event of a default as defined in the Collateral and Remedies Section of the Agreement, we may hold overpayments as security for the payment or performance of any of your Obligations to us. Any return or credit of such amounts shall not be an admission that all Obligations have been paid or performed.

3. Final Retrospective Plan Adjustment(s)

As of the Final Retrospective Plan Adjustment Date(s) set forth in the Key Dates part of the Program Summary, we will compute the Final Retrospective Plan Premium Adjustment Amount(s).

C. Payment Terms

You agree to pay each bill or invoice which is submitted to you in accordance with the payment terms set forth in such bill or invoice. If no payment terms are stated on such bill or invoice, payment shall be due within thirty (30) days of the date of such bill or invoice.

D. Right of Offset

We and you may offset any balance due between ourselves under this Agreement or any other such agreement or other property-casualty agreements heretofore or hereafter entered into between ourselves.

E. Collection Costs and Damages

Within five (5) days of our demand, you shall reimburse us for any and all costs and expenses, including, but not limited to, attorneys' fees, incurred by us in connection with the collection or enforcement of any of your Obligations to us. In addition, with respect to any of your Obligations that remain outstanding beyond the due date, you agree that we may charge you interest on that Obligation. If we choose to exercise this

option, interest shall accrue daily, at the prime rate of interest plus 200 basis points in effect daily at **J.P. MORGAN CHASE & CO., 270 PARK AVENUE, NEW YORK CITY, NEW YORK 10017-2070**, not to exceed the highest rate allowed by law, from the due date on the bill or invoice until the date we receive payment.

DEFAULTS & REMEDIES SECTION

A. Defaults and Remedies

1. You will be in default if you:
 - a. fail to pay any amount to us when due, or
 - b. fail to perform any Obligation or to satisfy any requirements under any Agreement Letters, any agreements incorporated herein by reference or other similar agreement(s) with us, or
 - c. fail to deliver to us within the time period specified or fail to continue to maintain any Letter of Credit or any renewal, replacement or amendment thereof required by this Agreement, or
 - d. become insolvent or unable to pay your debts as they become due or are declared bankrupt or insolvent, or if a debtor relief proceeding has been brought by or against you, or
 - e. make misrepresentations to us or breach any representations you have made to us, either orally or in writing.
2. If you are in default, then we will be entitled to immediately terminate some or all of your rights to defer payment of your Obligations, as such rights are set forth in this Agreement and we shall be entitled to immediately:
 - a. consider due and payable all of your Obligations to us including, but not limited to, those Obligations accruing in the future, and/or
 - b. satisfy amounts due us by drawing up to the full amount of any Letters of Credit held by us (whether pursuant to this Agreement or otherwise) and applying the proceeds to these amounts due and/or by continuing to hold the proceeds of the Letters of Credit until such time as we have determined your Obligations to us to be final, and/or bill you for all amounts that remain outstanding, and/or
 - c. terminate your insurance program or any insurance Policy issued thereunder and cancel or non-renew any certificates of insurance or financial responsibility filings made on your behalf, and/or
 - d. pursue any and all other legal and equitable rights and remedies available to us under applicable law, including, but not limited to, the seeking of injunctive relief for your failure to provide us with Letters of Credit pursuant to the terms of this Agreement.
3. After any default, at such time or such intervals of time as we determine, we may recalculate your Obligations pursuant to the terms of this Agreement and exercise at such time, or successively at such intervals, any of our rights and remedies described in this Agreement until we determine that your Obligations are final.

You agree that any credit or return due to you pursuant to the terms of this Agreement will be held by us as security for payment of any future Obligations that may develop. We may hold the proceeds of the Letters of Credit, and we may, from time to time, apply such Letter of Credit proceeds to any of your Obligations to us. We will return any Letters of Credit or proceeds therefrom we have not applied to Obligations to the issuing bank, when we deem that all Obligations finally developed have been paid, or when we, in our sole discretion, decide that we no longer need Collateral.

4. If you are in default of this Agreement and we decide to exercise our right to draw on the Letters of Credit, you acknowledge and agree that whatever Travelers company is named as beneficiary in any Letters of Credit issued pursuant to the requirements of this Agreement has the authority and ability to draw on the Letters of Credit as an agent for any and all Travelers company(ies).

GENERAL CONDITIONS SECTION

A. Failure of Enforcement

Our failure to enforce at any time any of the provisions of this Agreement, or to exercise any option which is herein provided, or to require at any time performance by you of any of the provisions hereof shall in no way be construed to be a waiver of such provisions, nor in any way to affect the validity of this Agreement or any part thereof, or our right to thereafter enforce each and every provision of this Agreement or to exercise any right or remedy available to us under applicable law.

B. Cancellation of Insurance Policies

1. If, pursuant to the conditions of any Policy, such Policy is canceled by either party prior to its expiration, for the purpose of calculating your Maximum Loss Content, the audited Exposure Base for that Policy shall be calculated by adding the audited Exposure Base from the beginning of the Policy period to the date of cancellation and the estimated Exposure Base for the balance of the original Policy period, subject to your Minimum Maximum Loss Content. If such Policy is canceled by either party, your Minimum Program Cost is a flat charge in the amount set forth in the Maximum Loss Content and Minimum Program Cost part of the Program Summary.
2. If, pursuant to the conditions of any Policy, such Policy is canceled prior to expiration, your audited Expense(s), to the extent not included in the Minimum Program Cost, will be calculated by using your audited exposure base from the beginning of the Policy period to the date of cancellation subject to any minimum Expense(s) set forth in the Expenses part of the Program Summary.

All other adjustments to premium will not be affected by such cancellations.

C. Executory Duties

The parties agree that, due to the unique rating features of this program, future performance of the terms of this Agreement by both parties is necessary and material to the accomplishment of the goals of this Agreement and that the parties have exchanged valuable consideration and will exchange consideration in the future. In support of these goals, the parties further agree, subject to applicable state and federal law, that the parties have unperformed material duties which are executory, including, but not limited to,:

1. Payment of Obligations; and
2. Cooperation in the furnishing of information regarding Claims pursuant to the terms and conditions of the Policies; and
3. Cooperation with us in the defense of Claims pursuant to the terms and conditions of the Policies; and
4. Investigation, administration and payment of Claims against you pursuant to the terms and conditions of the Policies.

The parties agree that this program affords benefits to you by virtue of the unique rating feature. Such benefits include, but are not limited to, protection from casualty loss, disruption of business, interruption of cash flow and diminution of your assets.

D. Binding Authority

You warrant and represent that the person who signs this Agreement has been duly authorized to execute the Agreement for and on behalf of you and those of your affiliates, divisions and subsidiaries, general partners and/or limited partners which are named insureds under the Policies and with respect to workers compensation insurance, who are employers referenced in Item 1. of the Information Pages of the workers compensation Policies, and that he or she has the authority to bind you and those affiliates, divisions and subsidiaries, general partners and/or limited partners jointly and severally to the terms hereof.

E. Agreement to Arbitrate

1. The parties recognize that disputes may arise between them, and in some instances involving non-parties as well, about the parties' rights and duties relative to payment of premium and other charges under this Agreement and the Policies. In addition, disputes may arise regarding whether and how much our claims handling practices (e.g., investigation, administration, payments in connection with any claims under the Policies) may impact the amount of premium and other charges which you may owe to us under this Agreement and the Policies. The parties will attempt to resolve those disputes without resort to formal procedures. However, in the event such a dispute is not resolved, either party shall submit the matter to arbitration and the other party shall be bound by such submission, provided that you shall not submit to arbitration any matter seeking to restrict our right to draw upon the Collateral or which would have the effect of restricting our right to draw upon the Collateral.
2. Neither party shall submit to arbitration (i) any coverage disputes which arise under or in connection with claims or suits brought against the Policies; and/or (ii) claims by or against you and other Travelers policyholders with respect to other insurance programs with Travelers; and/or (iii) claims by or against you and other policyholders of any other commercial lines property casualty insurer(s), including but not limited to any claim under (ii) or (iii) which you purport to arbitrate as a representative or member of a class or as a private attorney general.
3. In the context of workers compensation coverage, neither party shall submit to arbitration any dispute the resolution of which has been committed to the exclusive jurisdiction of any state or federal governmental entity.
4. The arbitrator(s) has no authority, and is not empowered, to consolidate or direct class-action arbitration as to any disputes between the parties to this Agreement with other disputes between Travelers and any other of its policyholders or other third parties. Nor shall the arbitrator(s) have authority or be empowered to consolidate or direct disputes brought by you as a private attorney general. Any determination by the arbitrator(s) to so consolidate or direct class-action arbitration or to consolidate or direct disputes brought by you as a private attorney general shall be beyond the arbitrator's authority and jurisdiction and shall accordingly, be void. Any dispute regarding these prohibitions against consolidation of class-action arbitrations and against disputes brought by you as a private attorney general shall be heard and resolved by a court having jurisdiction over the parties as provided in the Consent to Jurisdiction provision below, not the arbitrator(s).
5. The parties agree that your insurance program with us is deemed made in the State of Connecticut and involves interstate commerce. Accordingly, we and you agree that any arbitration proceeding arising out of or related to this Agreement shall be governed by the Federal Arbitration Act ("FAA") and, to the extent not inconsistent with the FAA, Connecticut arbitration law.
6. Arbitration Procedures
 - a. All such disputes shall be submitted for decision to a panel of arbitrators composed of two party-appointed arbitrators and an umpire (the "Arbitration Panel"). Each member of the Arbitration Panel shall be a disinterested, active or retired judge, or executive officer of a property-casualty insurance company or property-casualty broker authorized to transact business in the United States. The arbitration proceedings shall take place in Hartford, Connecticut unless otherwise agreed by the parties.
 - b. The party demanding arbitration ("Claimant") shall appoint its arbitrator first. The other party ("Respondent") shall appoint its arbitrator no later than two weeks after the date on which Respondent receives notice from Claimant of Claimant's appointment of its arbitrator. If the Respondent fails to appoint its arbitrator within such two week-period, then Claimant shall appoint the second arbitrator and Respondent shall forfeit any right to name the second arbitrator. The two arbitrators shall select an umpire within twenty one (21) days after both arbitrators have been appointed. If the two arbitrators fail to agree on an umpire within the twenty one (21) day period, each arbitrator shall name three umpire candidates, of whom the other arbitrator shall strike two and the decision shall be made from the remaining two umpire candidates by drawing lots.

- c. Notwithstanding anything in this 'Agreement to Arbitrate' Section to the contrary, if the amount claimed by the Claimant in its demand for arbitration is less than \$250,000, the parties agree that an abbreviated, streamlined arbitration procedure ("Streamlined Arbitration") will be followed. In such a case, the parties agree to submit the dispute to an Arbitration Panel comprised of a sole arbitrator. The sole arbitrator shall be a disinterested, active or retired judge, or executive officer of a property-casualty insurance company or property-casualty broker authorized to transact business in the United States. Within fourteen (14) days of the date the arbitration demand is served on Respondent, Claimant and Respondent shall each name three candidates. If a candidate appears on both lists of candidates, then that candidate shall be named the sole arbitrator to resolve the dispute. If there is no match on the lists, each party shall strike two names from the other's list and the sole arbitrator shall be selected from the remaining two candidates by drawing lots.

All Streamlined Arbitration proceedings shall be subject to the following rules:

- i. Each party will be permitted a maximum of three depositions.
- ii. The parties agree that time is of the essence and that the final hearing shall commence no later than six months from the date of the arbitration demand. The parties further agree that no continuances or extensions of time with respect to that six month period shall be granted unless both parties agree.
- iii. The sole arbitrator shall have the authority, in his/her discretion to decide the case without a formal hearing and based upon the written materials submitted by the parties.
- d. The Arbitration Panel is relieved from all judicial formalities and may abstain from following the strict rule of law. At the hearing, evidence may be introduced without following the strict rules of evidence, but cross examination and rebuttal shall be allowed.
- e. The Arbitration Panel shall issue its decision within fourteen (14) days following the conclusion of the hearings or, if the case is submitted on the briefs, within fourteen (14) days of the submission of the final briefs.
- f. The Arbitration Panel shall issue its decision in writing, identifying the reasons and rationale for the decision and, if the arbitration panel feels it is necessary, setting forth the findings of fact with respect to its decision.
- g. The decision of the majority of the Arbitration Panel shall be final and binding upon all parties to the proceeding. Judgment may be entered upon the award in any court having jurisdiction.
- h. The Arbitration Panel shall have authority to award pre-judgment interest, post-judgment interest, interim relief, pre-hearing security, and summary judgment.
- i. Each party shall bear the expense of its own arbitrator and shall jointly and equally bear with the other party all expenses of the umpire and of the arbitration. Unless otherwise required by statute, each party shall be responsible for its own attorneys' fees and costs.

F. Consent to Jurisdiction

Subject to the terms and conditions of this Agreement, in the event any suit is commenced to enforce any right hereunder, the non-suing party hereby irrevocably submits to, consents to and waives any objection to the jurisdiction of the courts of the State of Connecticut, including the United States District Court for the State of Connecticut. In connection with any such action, process may be served within or outside of the State of Connecticut by personal service or by registered mail, return receipt requested, addressed to the address set forth in the Notices part of the Program Summary, or such other address as the non-suing party may hereafter designate in writing. The parties agree and consent that the exclusive venue (subject to the applicable rules of the courts concerning the assignment or transfer of cases) for any such action shall lie in the County of Hartford in the State of Connecticut.

G. Large Risk Alternative Rating Option; Consent to Rate

Your Obligations under this Agreement are rated and priced in accordance with the terms of the National Council on Compensation Insurance ("NCCI") Large Risk Alternative Rating Option (Filing Memorandum R-1295), incorporated herein by reference. In addition, the parties recognize and acknowledge that you are paying certain rates and charges for your Obligations that may be more or less than the sum of charges that would be part of filed and approved rating plans for the underlying insurance coverages. To the extent that this is the case, you acknowledge that you have negotiated and consented to the prices and rates set forth in this Agreement.

H. Notice

Any notices or communications required to be given hereunder shall be in writing and sent by (i) overnight mail via a commercial courier who will provide evidence of delivery or (ii) electronic mail to the other party at the address set forth in the Notices part of the Program Summary. Such notices shall be deemed delivered when sent.

I. Assignment

This agreement is not assignable by any party, without the prior written consent of all parties.

J. Financial Information - Other Books and Records

You will furnish us with such financial information and other books and records as we may request from time to time, including but not limited to certified financial statements on an annual basis.

K. Termination of Agreement

This Agreement shall terminate when both parties agree that all Obligations finally developed hereunder have been paid and/or otherwise performed unless terminated earlier pursuant to the Collateral and Remedies Section.

L. Legal Agreement

Nothing in this Agreement shall be construed to require the commission of any act contrary to law. In the event of a conflict between any provision of this Agreement and any law or regulation contrary to which the parties have no legal right to contract, the latter shall prevail; provided however, that in such event, the provision so affected shall be limited only to the extent necessary to permit compliance with the minimum legal requirement, and all other provisions of this Agreement shall continue in full force and effect.

In the event of a conflict between any provision of this Agreement and any provision of any Policy, the Policy shall control.

The parties have read this Agreement and they have had a full opportunity to evaluate this Agreement along with all transactions and other matters contemplated by this Agreement. The parties have had the opportunity to consult with, and have consulted with, business advisors and counselors of their choice in connection with this Agreement. If any provision of this Agreement is found ambiguous by a court or arbitration panel, such provision shall not be construed against either party based on that party's alleged drafting of such provision.

M. Choice of Law

This Agreement shall be governed by the internal laws of the State of Connecticut, without regard to Connecticut's rules regarding conflict of laws. This choice of law provision applies to this Agreement and not to coverage disputes which may arise in connection with Claims or suits brought against the Policies.

N. Acceptance - Entire Agreement

This Agreement and the Program Summary, including the Exhibits referenced in the Exhibits part of the Program Summary, and including any Integrated Agreements referenced in the Integrated Agreements part of the Program Summary and any Policies or other documents incorporated herein by reference, constitute the entire, integrated agreement of the parties with respect to the subject matter hereof and may not be amended or modified except pursuant to a written agreement executed by authorized officers of both parties; however, except as set forth below, neither this Agreement nor any other Collateral delivered hereunder releases or supersedes any Collateral which you have provided or are obligated to provide as security for your Obligations to us, and all such Collateral shall remain in full force and effect until expressly released by us in writing pursuant to the terms of the agreement(s) under which it was provided.

Notwithstanding the foregoing, you agree that, at our option, any Collateral you have provided us prior to the date of this Agreement in connection with insurance programs shall be subject to all the terms of this Agreement. This shall include, but is not limited to the provisions of this Agreement, whereby the proceeds of such Collateral may be used to satisfy your Obligations to us. If, for any reason, such Collateral may not be subject to the terms of this Agreement, then such Collateral shall remain subject to the terms of the agreement(s) under which it was provided to us.

Please acknowledge your understanding of and agreement with this Agreement by signing one copy of the Agreement and returning it to us.

GARDEN FRESH RESTAURANT CORP

Accepted by: _____

Name (print): _____

Title: _____

Date: _____

The Travelers Indemnity Company

Accepted by: _____

Name (print): _____

Title: _____

Date: _____

FRAUD STATEMENT

CALIFORNIA: Auto: Any person who knowingly makes an application for motor vehicle insurance coverage containing any statement that the applicant resides or is domiciled in this state when, in fact, that applicant resides or is domiciled in a state other than this state, is subject to criminal and civil penalties. Other Than Auto: The "All Other States" statement applies to lines of business other than auto.

ALL OTHER STATES: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

MEDICAL COST CONTAINMENT EXPENSE COMPONENT OF ALAE

Your pricing structure consists of the following components, which apply to Claims with a date of accident beginning with the Program Effective Date set forth on the Program Summary:

1.a. There is a 27% charge applied to any Savings resulting from the following medical bill repricing, pharmacy bill repricing and hospital bill audit activity:

- Application of Preferred Provider Network discounts to physicians' bills, hospital bills and pharmacy bills
- Repricing as a result of negotiation of out-of-network physicians' bills, pharmacy bills and hospital bills
- Repricing of medical bills, pharmacy bills and hospital bills by reviewing the bills and applying state rules/edits and proprietary rules/edits
- Repricing of medical bills, pharmacy bills and hospital bills by manual bill review by our medical review team
- Repricing to any applicable state-mandated schedule.

b. Savings realized from medical bill, pharmacy bill and hospital bill review to which the 27% charge is not applied are:

- Savings realized from the detection and elimination of duplicate bills
- Savings achieved by the Claim case manager, i.e. bills containing unrelated/unauthorized treatment
- Savings achieved by the medical case manager, i.e. bills containing unapproved medical treatment
- Savings realized from the elimination of non-compensable bills.

For purposes of this Exhibit, the term "Savings" shall refer to the difference between the amount billed by physician, hospital, pharmacy and other medical providers and the amount we ultimately paid. We adhere to state-mandated fee schedules and/or usual and customary pricing for certain procedures, may contract with preferred provider networks which have contractual arrangements with certain of those providers to perform certain procedures at pre-determined rates (which may be below fee schedule), and may utilize other fee negotiation resources we determine are necessary and appropriate to determine the amount that we should pay on any given medical bill.

2. The 27% charge will be capped at \$10,000 per bill and is charged to the Claim file as an Allocated Loss Adjustment Expense, unless we are required by state law to charge it to the Claim file as a different component of the applicable rating plan. The \$10,000 per bill cap applies to bills with a date of service beginning with the Program Effective Date set forth on the Program Summary.

3. Certain items are still charged separately to the Claim file as Allocated Loss Adjustment Expenses. These items include but are not limited to:

- Utilization Review [pre-certification and concurrent review] services charged on a per activity basis
- Independent medical examinations*
- Second opinions by a physician*
- Chiropractic reviews
- Physician advisor programs.

*unless ordered by an industrial board or state equivalent, in which case it is treated as Medical.

POLICY EXHIBIT

1. Insurance Policies

Policy Number	Type of Coverage	States	Plan Type	Company
TRJUB-4246B092-14	Workers Compensation and Employers Liability	CA	Retro	TIL

The Policies shown above are issued in one or more of the following Travelers companies. The above company translates as follows:

TIL Travelers Property Casualty Company of America

The above company has an address of One Tower Square, Hartford, CT 06183-7312.

The omission of, or failure to include, any Policy on this Policy Exhibit, shall not relieve you of any of your duties or Obligations under this Agreement or under the Policies.

TERRORISM

Terrorism Risk Insurance Act of 2002 Disclosure

On December 26, 2007, the President of the United States signed into law amendments to the Terrorism Risk Insurance Act of 2002 (the "Act"), which, among other things, extend the Act and expand its scope. The Act establishes a program under which the Federal Government may partially reimburse "Insured Losses" (as defined in the Act) caused by "acts of terrorism". An "act of terrorism" is defined in Section 102(l) of the Act to mean any act that is certified by the Secretary of the Treasury – in concurrence with the Secretary of State and the Attorney General of the United States – to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States Mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

The federal government's share of compensation for Insured Losses is 85% of the amount of Insured Losses in excess of each Insurer's statutorily established deductible, subject to the "Program Trigger", (as defined in the Act). In no event, however, will the federal government or any Insurer be required to pay any portion of the amount of aggregate Insured Losses occurring in any one year that exceeds \$100,000,000,000, provided that such Insurer has met its deductible. If aggregate Insured Losses exceed \$100,000,000,000 in any one year, your coverage may therefore be reduced.

The charge for Insured Losses is included in the total premium for each coverage indicated in this Agreement. The charge that has been included for each coverage is indicated below and does not include any charges for the portion of losses covered by the federal government under the Act.

Coverage	Included Charge For Insured Losses
Workers' Compensation	<p>Exposures in states <u>other than</u> Alaska, Florida and North Carolina: 1.5% of the total Workers Compensation premium. Deductible Policies will be subject to any applicable adjustments or audits. For retrospective Policies (if any), the charge will be a flat charge which is charged at policy inception, not subject to any retrospective premium adjustments or audits.</p> <p>Note: The foregoing rates are subject to change at any time based upon state regulatory action.</p>



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

Dear Policyholder:

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

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

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

www.travelers.com/CAMPN

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

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

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

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

Sincerely,

Travelers

W04NIB09

Page 1 of 1

MEDICAL AUTHORIZATION

RE: Name:

Date:

SS#:

Claim Number:

DOB:

YOU ARE HEREBY AUTHORIZED TO RELEASE TO

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

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

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

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

The purpose for releasing this information is:

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

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

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

DATE

SIGNATURE

PRINT NAME

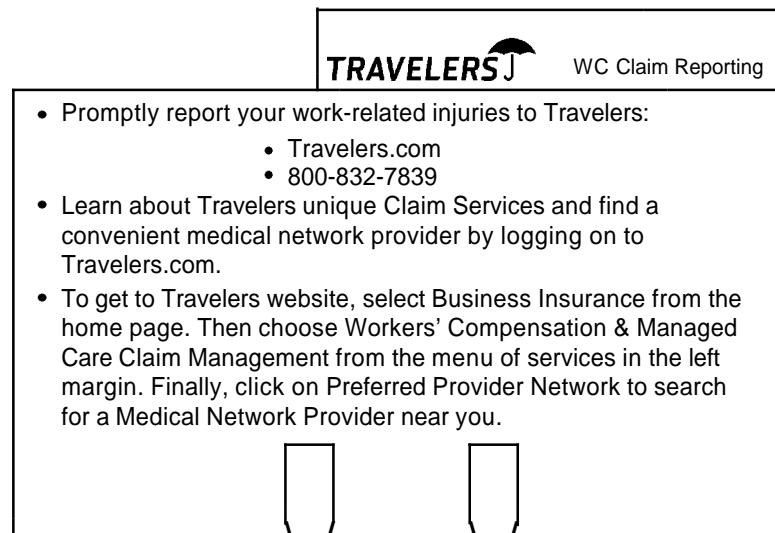
If Your Employee Is Injured At Work

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

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

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

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



NOTICE TO EMPLOYEES

Longshore and Harbor Workers' Compensation Act

U.S. Department of Labor

Employment Standards Administration

Office of Workers' Compensation Programs

(Employer) **GARDEN FRESH RESTAURANT CORP**

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

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

WHAT TO DO WHEN INJURED AT WORK

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

Insurance Carrier for This Employer	For Further Assistance and Information
Name THE TRAVELERS INSURANCE COMPANIES	On request, the Office of Workers' Compensation Programs will explain benefits and proceedings under the above Act. In addition, the Office of Workers' Compensation Programs will inform employees receiving compensation about medical and vocational rehabilitation services, and will assist in obtaining such services.
Address ONE TOWER SQUARE HARTFORD, CT 06183	
Telephone 800 832-7839	
Policy Number (TRJUB-4246B09-2-14)	Expiration Date of Policy 04-01-15

Authorized Signature for the Employer

Date Signed

This Notice must be posted and maintained in a conspicuous place in and about the place of business.
(33 U.S.C. 934)

Important Notice

Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed \$10,000, by imprisonment not to exceed five years, or by both.

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

 YES NO

TREATMENT ("X" ALL THAT APPLY)

<input type="checkbox"/> FIRST AID —	TREATMENT AND DATE OF 1 st TREATMENT	
<input type="checkbox"/> HOSPITAL/CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 st TREATMENT, LENGTH OF STAY AMBULANCE USED?	
	WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATENT? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PHYSICIAN —		

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

Alabama

Employee's County:

Return to work (Y/N):

At what Occupation:

At what Wage \$:

Return to work wage is per (Day, Week or Month):

Employer's ID (U.C. Account) Number:

What Specific Product(s) does the business produce:

Alaska - No Additional State Questions

Arizona

Last Day of Work after injury:

Number of Days per Week Company usually Works:

Department Number:

If Validity of Claim is Doubtful, state Reason:

Has injured been employed for more than 12 months (Y/N):

Was employee on overtime when injured (Y/N):

Arkansas - No Additional State Questions

California

State Unemployment Insurance Account Number:

Date employee was provided Employee Claim Form:

Has your employee pre-designated a primary treating physician (Y/N):

If Yes, Primary Treating Physicians

First Name: Last Name: Street Address:

City: State: Zip: Phone:

If No, did your employee require medical treatment (Y/N):

If Yes, Treating Physicians

First Name: Last Name: Phone:

If No, and employee requires medical treatment in the future, you can go to our website WWW.MYWCOMPINFO.COM to find a provider in the Medical Provider Network.

Colorado

Employer Federal ID Number

Does Employer have a salary continuation program (Y/N):

If "Yes" is this program registered with the state (Y/N):

Connecticut - No Additional State Questions

Delaware

Employer's UC Reporting Number:

Employees County:

Returned to work (Y/N): If Yes, at same wage (Y/N):

District of Columbia

Employer ID Number:

Returned to work (Y/N):

If Yes, at what Time: AM/PM

At what Wage \$: Per (Day, Week or Month):

Was injured hired in DC (Y/N):

Was employee in his/her regular occupation when injured (Y/N):

Was injured given Form #7 DCWC (Y/N):

Piece or Time Worker (piece, time or blank):

Florida - No Additional State Questions

Georgia

Wage Rate at time of injury \$: Per:

First Date employee failed to work a full day:

Did employee work the next day (Y/N):

Return to work Wage \$:

Return to work wage is per (Day, Week or Month):

Hawaii

Was employee furnished meals or lodging (Y/N):

Idaho - No Additional State Questions

Illinois

Has the injured worker signed a medical authorization (Y/N):

If yes, inform them to please fax the signed medical authorization to the med auth customer service specialist at 1-877-786-5567.

Indiana - No Additional State Questions

Iowa - No Additional State Questions

Kansas

SIC Code:

Was worker admitted to hospital (Y/N):

If Yes, Date of Admission:

Was worker treated in emergency room only (Y/N):

Returned to work (Y/N):

If employee has returned to work, was return to light duty (Y/N):

Is further medical aid needed (Y/N):

Is compensation now being paid (Y/N):

If Yes, Date of first Initial Payment:

Fatal (Y/N):

If Yes, Name and Address of Dependents:

Kentucky - No Additional State Questions

Louisiana

Employer's Federal ID Number:

Employer's Unemployment Insurance Reporting Number:

Returned to work (Y/N):

If Yes, at same wage (Y/N):

Last Full Day Paid:

If occupational disease, Date of Initial Diagnosis:

Parish (county) where injury occurred:

Maine

Employer's State Unemployment Insurance Account Number (UIAN):

Federal Employer Insurance Number (FEIN):

Maryland - No Additional State Questions

Massachusetts

Federal ID Number:

Returned to work (Y/N):

Did employee return to his/her regular occupation (Y/N):

Describe nature of business or article manufactured (S=Service,

W=Wholesale, R=Retail, M=Manufacturing):

Date Reported as work related:

Michigan

Federal ID Number:

Minnesota

Date employer notified of lost time:

NAICS Code Number:

Mississippi - No Additional State Questions

Missouri - No Additional State Questions

Montana - No Additional State Questions

Nebraska - No Additional State Questions

Nevada

How long employed by you in Nevada Years: Months:

If Validity of Claim is Doubtful, state Reason:

New Hampshire

Federal I.D. Number:

Was the employee injured in his/her regular occupation (Y/N):

Was injured hired in New Hampshire (Y/N):

Number of Full-Time Employees:

Number of Part-Time Employees:

If leased or temporary worker, provide the Client's Business Name:

Was accident caused by injured's failure to use safeguards or follow regulations (Y/N):

Probable Length of Disability:

Returned to work (Y/N):

At what Occupation:

Returned at Full Duty:

Returned at Alternative/Light Duty:

Initial treatment ("X" all that apply)

No medical treatment: Care provided by employer only (on-site): Emergency Care: Hospitalized: Outpatient:

Clinic:

Office Visit: Other-explain:

Is there a managed care program (Y/N):

WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

If Yes, Name of Provider:

Is there a written safety program in force (Y/N):

Is there an active safety committee (Y/N):

Employee's Legal First Name (please validate):

New Jersey - No Additional State Questions

New Mexico - No Additional State Questions

New York

Did you provide medical care (Y/N):

If Yes, When:

Returned to work (Y/N):

If Yes, at what Weekly Wage \$:

Injured workers Work Week (indicate days regularly worked):

Fatal (Y/N):

If Yes, Name and Address of nearest relative:

Relationship:

North Carolina

Regular Wages per Day \$:

Average Weekly Wages with Overtime \$:

Returned to work (Y/N):

If Yes, at what Time: AM/PM

If Yes, what Date:

Return to work at what Wage \$: Per (Day, Week or Month):

Return to work at what Occupation:

North Dakota - No Additional State Questions

Ohio

Time Accident Reported to employer: AM/PM:

Has employee ever filed a previous application for this injury (Y/N):

Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):

If Yes, specify Claim Number and Body Parts:

Employee's County:

Current Employer's Risk Number:

Oklahoma

Was employment agreement made in Oklahoma (Y/N):

SIC Number:

Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):

Oregon

Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):

Was accident caused by failure of machinery or product (Y/N):

Did someone (not worker) cause accident (Y/N):

Time worker left work: AM/PM:

Pennsylvania

Employee's County:

Bureau Code:

NAICS Code:

Employer's County:

Are you aware of a 'Panel of Physicians' for your Employer? (Y/N)

Rhode Island

Federal ID Number:

First Full Day Lost from work:

Unemployment Insurance Number:

State of Hire:

Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):

If Yes, Date Employer first Notified of medical treatment or lost time:

Category of Injury or Illness ("X" all that apply):

Injury: Illness: Occupational Disease: Repetitive Trauma:
Occupational Hearing Loss: Unknown:

South Carolina - No Additional State Questions

South Dakota

Federal ID Number:

Number of employees:

Body Part Injured Code (2 digits):

Cause of Injury Code (2 digits):

Nature of Injury Code (2 digits):

Was employee hired for temporary employment (Y/N):

Carrier Code:

Tennessee - No Additional State Questions

Texas - No Additional State Questions

Utah - No Additional State Questions

Vermont

Federal ID Number:

Was employee hired in Vermont (Y/N):

Does the employer regularly employ 10 or more employees (Y/N):

Returned to work (Y/N): If Yes, at what Weekly Wage \$:

Was injured paid in full for the date disability began (Y/N):

Was employee injured at his/her regular occupation (Y/N):

Fatal (Y/N):

If Yes, Name, Address and Relationship of Nearest Relative:

Last Date Paid in Full:

Virginia

Returned to work (Y/N): If Yes, at what Wage \$:

Federal Tax ID Number:

Washington - No Additional State Questions

West Virginia

Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)

Wisconsin - No Additional State Questions

Wyoming - No Additional State Questions

U.S. Longshoreman (USDOL) - No Additional State Questions

DISCLOSURE FORM WORKERS' COMPENSATION INSURANCE

IMPORTANT NOTICE TO POLICYHOLDER

1. NOTICE OF CHANGE IN RATE BY CLASSIFICATION

If you desire information whenever there is a change in your workers' compensation insurance rate by classification, you must request such information from your insurer. This request for information must be in writing.

2. NOTICE OF POLICYHOLDERS' RIGHT TO APPEAL CLASSIFICATION

Your insurer can charge and collect any additional amount of money not included in the initial premium charged as a result of job misclassification.

If you have any questions regarding the employee classification assigned to calculate your workers' compensation insurance premium, you need to direct your questions to your insurer or the insurer's authorized representative within either thirty (30) days after the anniversary date of the policy or the date of receipt by you of notice of a change in job classification. Within thirty (30) days after receipt of your request for information, your insurer or the insurer's authorized representative must explain to you why a particular employee classification was used.

If you disagree with your insurer or the insurer's authorized representative on the employee classification assignment, you may appeal to the Workers' Compensation Classification Appeal Board by filing written notice with said board within thirty (30) days after you have exhausted all appeal review procedures provided by the insurer. Your request should be sent to the Secretary of the Colorado Workers' Compensation Classification Appeals Board, c/o National Council on Compensation Insurance, Inc. (NCCI), 7220 West Jefferson Avenue, Suite 310, Lakewood, CO 80235. Written instructions for your appearance before the Colorado Workers' Compensation Classification Appeals Board will be furnished by the Secretary of the board. The board will render a decision as to whether a misclassification has occurred.

A decision by the board is final and not subject to appeal unless you, the insurer provides written notice of appeal within thirty (30) days after the board's decision to the office of the Commissioner of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. The Commissioner shall review any decision of the board properly appealed.

3. NOTICE OF AVAILABILITY OF MEDICAL CASE MANAGEMENT SERVICES

We have many types of medical case management services available and suggest that you contact our local claim office for an explanation of services available to you.



PRIVACY NOTICE

THE TRAVELERS INSURANCE COMPANIES

PRIVACY POLICY

Thank you for selecting **THE TRAVELERS INSURANCE COMPANIES** as your workers compensation insurer. At **THE TRAVELERS INSURANCE COMPANIES** a subsidiary of Travelers, we recognize that privacy is important to you. That is why we are committed to protecting your privacy through the adoption of the following privacy principles:

Collection Of Information

We collect, retain, and use information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, only where we believe that it will help or is necessary to provide you products and services or otherwise conduct our business. We collect nonpublic personal financial information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, from the following sources:

- information we receive from you or through your agent or broker on applications or other forms;
- information we receive from or about you in the process of adjusting claims;
- information about your other transactions, including risk control and other consulting services, with us, our affiliates or other third parties;
- information about your coverages and loss activity with other carriers; and
- information we receive from a consumer reporting agency.

Such information includes identifying information such as policyholder, participant, beneficiary or claimant name, address, and social security number; financial information such as income, payment history, or credit history; and, under certain circumstances, health information such as information about an illness, disability, or injury. It could also include information on claims with other insurance companies and us and the condition and maintenance of your property.

Disclosure Of Information

We usually do not disclose nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, without your consent. However, in some circumstances we may disclose information to others without your prior authorization. The most common disclosures are to the following persons:

- our affiliated property and casualty insurance companies;
- state insurance departments, for their regulation of our business;
- other government authorities;
- our agents and brokers as necessary to conduct our business;
- organizations that perform underwriting and claims investigations;
- another insurance company to which you have applied for a policy or submitted a claim;
- insurance support agencies, law enforcement agencies and our reinsurers; and
- any other third party, as permitted or required by law.

Most importantly, THE TRAVELERS INSURANCE COMPANIES does not and will not disclose or sell nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to anyone for marketing purposes.

Confidentiality And Security

We restrict access to nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to those who need it to serve your insurance needs and to maintain and improve customer service. We maintain physical, electronic, and procedural safeguards that comply with federal and state laws and regulations to guard your nonpublic personal information.

Disclosure and Protection of Former Customers' Information

We may disclose all the personal information we have collected, as described above. However, even if you no longer have a customer relationship with us, we will continue to follow our privacy policies and practices to protect your information.

Changes In Privacy Policy

We may choose to modify our policy regarding the treatment of personal information at any time. Before we do so, we will notify you and provide an updated privacy notice.

IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION

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

For information about how Travelers compensates independent agents and brokers, please visit www.travelers.com, call our toll-free telephone number 1-866-904-8348, or request a written copy from Marketing at One Tower Square, 2GSA, Hartford, CT 06183.

IMPORTANT NOTICE – NON-COOPERATION WITH PREMIUM AUDIT

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

Voluntary Audits (Non-Physical Audits Completed via Email or Internet)

A request for information will be sent to you at policy expiration. A second request will be sent 30 days later if no response has been received. If sixty (60) days have elapsed and the requested information is not received, the payroll will be increased with an estimate of 50%.

Physical Audits

A letter will be mailed to you informing you that a physical audit will be performed. An audit appointment will be requested with you multiple times. If sixty (60) days have elapsed and you fail to schedule an appointment, the payroll will be increased with an estimate not to exceed 300%.

In all cases, if complete audit information is received subsequently from you, the final audit will be revised using actual payroll once it has been verified.

IMPORTANT Policy Audit Information

Dear Policyholder:

This policy is issued with an estimated premium based upon information provided through your Producer. This premium is subject to adjustment at the end of the policy period. At that time, you may receive a request for information in the mail or a premium auditor may contact you to review the necessary records. The information developed is needed to determine the final earned premium for this policy.

Record Maintenance

In order to facilitate audit service, it is necessary to maintain proper records and have them available at the proper time. Based on the nature of your business, some of the following data will be necessary to complete the audit:

1. General Ledger, Financial Statements
2. Payroll Records, Time Books, State Unemployment Returns, FICA Returns, Individual Earnings Records-Monthly totals separated by type of work and overtime.
3. Cash Receipts, Sales Journal
4. Cash Disbursements Journal - Including subcontractors, casual labor and material costs.
5. Certificates of Insurance

IMPORTANT COVERAGE NOTE:

If you utilize subcontractors whose legal status is that of sole proprietor/partner, we may charge premium for these persons as provided under Part 5 of the policy contract even though certificates of insurance may exist. Please contact your producer if you have any questions regarding your Workers' Compensation coverage needs.

Work in Other States

Please advise your Producer if employees are hired for work in states other than those listed in Item 3. of your policy. This will enable your producer to consider your need for coverage in accordance with state laws.

We appreciate the opportunity to serve you. If you have any questions about the enclosed policy or any insurance matters please contact your producer or your Company representative.



ALASKA

NOTICE TO INSURED

Dear Policyholder:

This is to notify you that your Workers' Compensation and Employers Liability policy does not provide Other States Coverage for the State of Alaska.

If you have operations or start up an operation in Alaska, and it is not listed in Item 3A of the Information Page, you or your agent must notify us and request that this state be covered under your policy.

With receipt of your request for coverage, we will extend the policy to include this state.

Your Agent can provide you with necessary information and will assist you in obtaining coverage for this state.

ARIZONA
WORK EXPOSURE TO BODILY FLUIDS
(HIV & AIDS)

Dear Policyholder:

The Arizona Industrial Commission requires Employers to post Immediately Adjacent to the "Notice To Employers" an English language notice entitled "Work Exposure To Fluids". For those Employers who have a Spanish speaking work force the "Work Exposure To Fluids" is also printed in Spanish.

In addition, the Employer must also supply their Employees the Reporting Forms (Sample Attached) needed to report such exposures to bodily fluids. The Employer may secure a supply of these Reporting Forms from the Industrial Commission of Arizona.

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws.

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.
2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or might create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.
3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per \$100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.
4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.
5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.
6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.
7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

PN 04 99 02 B
(Ed. 5-02)

3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.
4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.
6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.
 - (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code Section 11750.3(c).
 - (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

This notice does not change the policy to which it is attached.

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. INFORMATION AVAILABLE TO YOU

A. Information Available from Us The Travelers Companies

- (1) General questions regarding your policy should be directed to:

TRAVELERS
 P.O. Box 6512
 21688 Gateway Center Drive
 Diamond Bar, CA 91765
 Phone: 1-909-612-3609
 Fax: 1-909-612-3629
 Website: www.travelers.com

- (2) **DIVIDEND CALCULATION.** If this is a participating policy (a policy on which a dividend may be paid), upon payment or non-payment of a dividend, we shall provide a written explanation to you that sets forth the basis of the dividend calculation. The explanation will be in clear, understandable language and will express the dividend as a dollar amount and as a percentage of the earned premium for the policy year on which the dividend is calculated.

- (3) **CLAIMS INFORMATION.** Pursuant to Sections 3761 and 3762 of the California Labor Code, you are entitled to receive information in our claim files that affects your premium. Copies of documents will be supplied at your expense during reasonable business hours.

For claims covered under this policy, we will estimate the ultimate cost of unsettled claims for statistical purposes eighteen months after the policy becomes effective and will report those estimates to the Workers' Compensation Insurance Rating Bureau of California (WCIRB) no later than twenty months after the policy becomes effective. The cost of any settled claims will also be reported at that time. At twelve-month intervals thereafter, we will update and report to the WCIRB the estimated cost of any unsettled claims and the actual final cost of any claims settled in the interim. The amounts we report will be used by the WCIRB to compute your experience modification if you are eligible for experience rating.

B. Information Available from the Workers' Compensation Insurance Rating Bureau of California

- (1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USR) and the *California Workers' Compensation Experience Rating Plan—1995* (ERP). Contact information for the WCIRB is: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. You may also contact WCIRB Customer Service at 1-888-229-2472, by fax at 415-778-7272, or via the Internet at the WCIRB's website: <http://www.wcirb.com>. The regulations contained in the USRP and the ERP are available for public viewing through the WCIRB's website.

- (2) **POLICYHOLDER INFORMATION.** Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Custodian of Records. The Custodian of Records can be reached by telephone at 415-777-0777 and by fax at 415-778-7272.

- (3) **EXPERIENCE RATING FORM.** Each experience rated risk may receive a single copy of its current Experience Rating Form free of charge by completing a Policyholder Rate Sheet Request Form on the WCIRB's website at <http://www.wcirb.com/ratesheet>. The Experience Rating Form will include a Loss-Free Rating, which is the experience modification that would have been calculated if \$0 (zero) actual losses were incurred during the experience period. This hypothetical rating calculation is provided for informational purposes only.

II. DISPUTE PROCESS

You may dispute our actions or the actions of the WCIRB pursuant to CIC Sections 11737 and 11753.1.

A. Our Dispute Resolution Process.

If you are aggrieved by our decision adopting a change in a classification assignment that results in increased premium, or by the application of our rating system to your workers' compensation insurance, you may dispute these matters with us. If you are dissatisfied with the outcome of the initial dispute with us, you may send us a written Complaint and Request for Action as outlined below.

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:

TRAVELERS

11090 White Rock Road
Rancho Cordova, CA 95670-6001

Phone: 1-800-328-2189

Website: www.Travelers.com

TRAVELERS

P.O. Box 6512
21688 Gateway Center Drive
Diamond Bar, CA 91765

Phone: 1-909-612-3609

Fax: 1-909-612-3629

Website: www.Travelers.com

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether or not your written request will be reviewed. If we agree to review your request, we must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If we decline to review your request, if you are dissatisfied with the decision upon review, or if we fail to grant or reject your request or issue a decision upon review, you may appeal to the insurance commissioner as described in paragraph II.C., below.

B. Disputing the Actions of the WCIRB. If you have been aggrieved by any decision, action, or omission to act of the WCIRB, you may request, in writing, that the WCIRB reconsider its decision, action, or omission to act. You may also request, in writing, that the WCIRB review the manner in which its rating system has been applied in connection with the insurance afforded or offered you. For requests related to classification disputes, the reporting of experience, or coverage issues, your initial request for review must be received by the WCIRB within 12 months after the expiration date of the policy to which the request for review pertains, except if the request involves the application of the Revision of Losses rule. For requests related to your experience modification, your initial request for review must be received by the WCIRB within 6 months after the issuance, or 12 months after the expiration date, of the experience modification to which the request for review pertains, whichever is later, except if the request for review involves the application of the Revision of Losses rule. If the request involves the Revision of Losses rule, the time to state your appeal may be longer. (See Section VI, Rule 14 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. Customer Service can be reached by telephone at 1-888-229-2472, and by fax at 415-778-7272.

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether or not your written request will be reviewed. If the WCIRB agrees to review your request, it must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If the WCIRB declines to review your request, if you are dissatisfied with the decision upon review, or if the WCIRB fails to grant or reject your request or issue a decision upon review, you may appeal to the insurance commissioner as described in paragraph II.C., below. Written Complaints and Requests for Action should be forwarded to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Complaints and Reconsiderations. The WCIRB's telephone number is 1-888-229-2472, and the fax number is 415-371-5204.

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- C. California Department of Insurance – Appeals to the Insurance Commissioner.** If, after you follow the appropriate dispute resolution process described above, we or the WCIRB decline to review your request, if you are dissatisfied with the decision upon review, or if we or the WCIRB fail to grant or reject your request or issue a decision upon review, you may appeal to the insurance commissioner pursuant to CIC Sections 11737, 11752.6, 11753.1 and Title 10, California Code of Regulations, Section 2509.40 et seq. You must file your appeal within 30 days after we or the WCIRB send you the notice rejecting review of your Complaint and Request for Action or the decision upon your Complaint and Request for Action. If no written decision regarding your Complaint and Request for Action is sent, your appeal must be filed within 120 days after you sent your Complaint and Request for Action to us or to the WCIRB. The filing address for all appeals to the insurance commissioner is:

Administrative Hearing Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco, California 94105

You have the right to a hearing before the insurance commissioner, and our action, or the action of the WCIRB, may be affirmed, modified, or reversed.

III. RESOURCES AVAILABLE TO YOU IN OBTAINING INFORMATION AND PURSUING DISPUTES

- A. Policyholder Ombudsman.** Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the insurance commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Policyholder Ombudsman. The policyholder ombudsman can be reached by telephone at 415-778-7159 and by fax at 415-371-5288.
- B. California Department of Insurance – Information and Assistance.** Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 1-800-927-HELP (4357) or <http://www.insurance.ca.gov>. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

This notice does not change the policy to which it is attached.

POLICYHOLDER NOTICE

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent, the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" or "CA Surcharge (CIGA) Surcharge" with an amount will be displayed on your premium notice.

This notice does not change the policy to which it is attached.



Your Workers' Compensation Benefits – California

This form should be given to all newly hired employees in the State of California. Its content applies to industrial injuries on or after January 1, 2013.

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

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

Workers' compensation benefits include:

Medical Care: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. Physical therapy, occupational therapy and chiropractic visits may be limited to 24 each.

Temporary Disability Benefits: Payments if you lose wages while recovering. For most injuries after April 18, 2004, temporary disability benefits are limited to 104 weeks within 5 years from your date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TTD benefits are terminated, delayed or denied.

Permanent Disability Benefits: Payments if your injury causes a permanent disability. Once your injury stabilizes, your treating physician may find permanent disability, depending upon your level of recovery. The amount of permanent disability found by your doctor will be rated by your claims administrator according to your age and occupation in order to determine the percentage and corresponding dollar amount of permanent disability due. These amounts are set by state law. You have the right to obtain a state disability rating or appeal a rating.

Return to Work Program: If you experience a permanent earnings loss as a result of your injury and your permanent disability benefits are determined to be disproportionately low, you may qualify for additional monies from the Department of Industrial Relation's Return to Work Fund. Contact the Department of Industrial Relations at: www.dir.ca.gov/ to learn more about this additional benefit.

Supplemental Job Displacement Vouchers: If your injury causes you to miss time from work and results in permanent disability, you may receive a supplemental job displacement voucher if your employer has not offered modified, alternative or regular employment within 60 days of receipt of the doctor's medical report indicating you have made a maximum medical recovery. The voucher is for reimbursement of education-related costs and is capped at \$6,000.00. If you receive a voucher as a result of your injury, you have two years from the date you are furnished the voucher or five years from your date of injury (whichever occurs later), to request reimbursement for qualifying expenditures.

Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness. Burial expenses are also provided, with the maximum amount allowed dependent upon the date of injury.

Temporary disability, permanent disability, and death benefits are all payable at a rate based on 2/3 of your average weekly wage, and subject to state minimum and maximum amounts in effect on your date of injury. These benefits are paid every two weeks while you are eligible.

Voluntary, off duty, recreational, social or athletic activities may not be covered under workers' compensation.

If you get hurt:

Get Medical Care. If you need first aid, contact your employer. If you need emergency care, call for help immediately.

Report Your Injury. Report the injury immediately to your supervisor. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury, and must also authorize treatment within one working day after you have returned a signed and completed copy of the form. The statute of limitations for filing a workers' compensation claim is one year from the date of injury or, if resulting from repeated exposures, one year from when you realized or should have realized that your job caused the injury.

See Your Treating Physician. Your primary treating physician is the doctor with overall responsibility for treating your injury or illness. He or she is charged with maintaining the continuity of your care, as well as initiating referrals to specialists. If your employer has an approved Medical Provider Network (MPN), they may be able to limit your choices of treating physicians retain medical control, and require you to treat with an MPN physician from the onset. (An MPN is a selected network of healthcare providers who provide treatment to workers injured on the job. See your employer for more information on your MPN.) Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If your employer does not have an approved MPN and you wish to change doctors in the first 30 days after reporting your claim, your claims administrator must select a new physician within five days of your request.

If you have provided your employer with the name of your personal physician before your injury and have group health insurance at the time of injury, you may see your personal physician for treatment even if your employer has an approved MPN. Your personal physician must be a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, or multi-specialty medical group of doctors of medicine or osteopathy, and must have treated you and maintained your medical history and records before your work injury and must also agree to treat you for a work-related injury or illness. If your employer does not have an approved MPN and you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request. If you still need medical care after 30 days, you may be able to switch to a doctor of your own choice.

For your convenience, optional forms to predesignate your personal physician or multi-specialty medical group of doctors of medicine or osteopathy are attached to this document. Also attached, are forms to predesignate your personal acupuncturist or chiropractor if your employer does not have a medical provider network in place. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If your employer has been found to discriminate, you may be entitled to job reinstatement with back pay, increased compensation, and costs and expenses. You may also have additional rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-3362. You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401** or learn more online at: <http://www.dir.ca.gov>.

If medical care is not being provided by your employer you have several options. First, contact your claims administrator to find out the status of your claim. If you have given your employer a completed and signed claim form but your claim has been delayed for investigation, your employer is still required to authorize treatment, up to \$10,000.00, during the delay. If the claim has not been accepted yet and your medical costs have exceeded the statutory \$10,000.00 cap, you can go to your group health plan for care, find a doctor, clinic or hospital that will bill the claims administrator directly, or use public health services.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it.

Your Workers' Compensation Insurance Company is **Travelers Property Casualty Company of America**.

You can also look up your insurance carrier at the WCIRB online lookup: <https://www.caworkcompcoverage.com/>

You can obtain free information from an Information and Assistance Officer of the state Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling **(800) 736-7401**. A list of Information and Assistance offices can be found at the end of this pamphlet to help you locate the I&A office nearest you. You may also go to the DWC web site at: <http://www.dir.ca.gov> for further information.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at: <http://www.californiaspecialist.org>. You may get a list of attorneys from your local information and assistance officer or look in your yellow pages.

Predesignation of personal physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) or medical group if:

- you have group health coverage at the time of injury;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

Notice of predesignation of personal physician

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____ (Name of Doctor, M.D., D.O., or medical group)

_____ (Street address, city, state, zip code)

_____ (Telephone number)

Employee Name (please print): _____

Employee's Address: _____

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____
(Physician or designated employee of the physician or medical group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Notice of personal chiropractor or personal acupuncturist

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify your employer of your personal chiropractor or acupuncturist. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Your Chiropractor or Acupuncturist's Information:

(Name of chiropractor or acupuncturist)

(Street address, city, state, zip code)

(Telephone Number)

Employee Name (please print): _____

Employee Address _____

Employee's Signature _____

Date: _____

Contact the information & assistance unit:

- By phone at 1-800-736-7401 – For recorded information that helps injured workers, employers and others understand California's workers compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

Anaheim 1065 N. PacifiCenter Drive Anaheim 92806 (714) 414-1801	Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	San Diego 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	Oxnard 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	San Francisco 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	Pomona 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	San Jose 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292
Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	Redding 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047	San Luis Obispo 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
Goleta 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158	Riverside 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	Santa Ana 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	Sacramento 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	Santa Rosa 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	Salinas 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	Stockton 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Marina del Rey 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	San Bernardino 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	Van Nuys 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

Administrative Director of the Division of Workers' Compensation. This form cannot be altered.



Sus Beneficios de compensación laboral – California

Este formulario debe entregarse a todos los empleados recién contratados en el estado de California. Su contenido se aplica a los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.

Cualquier persona que haga o propicie que se haga cualquier declaración sustancial a sabiendas falsa o fraudulenta con el propósito de obtener o denegar beneficios o pagos de compensación laboral es culpable de un delito.

Usted puede tener derecho a beneficios de compensación laboral si resulta lesionado o se enferma a causa de su trabajo, o si es víctima de un delito en el lugar de trabajo. La compensación laboral cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un acontecimiento (como lastimarse la espalda en una caída) o por exposiciones repetidas a una circunstancia perjudicial (como lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Los beneficios de compensación laboral incluyen:

Atención médica: consultas médicas, servicios hospitalarios, fisioterapia, análisis de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar su lesión. No debe recibir nunca una factura. Es posible que las visitas para fisioterapia, terapia ocupacional y al quiropráctico tengan un límite de 24 visitas para cada tipo.

Beneficios por incapacidad temporal: Pagos si usted deja de recibir su salario mientras se recupera. Para la mayoría de las lesiones ocurridas después del 18 de abril de 2004, los beneficios por incapacidad temporal se limitan a 104 semanas dentro del lapso de 5 años a partir de la fecha de la lesión. Presentar de forma oportuna una reclamación en el Departamento de Desarrollo Laboral (Employment Development Department) puede conducir a la obtención de beneficios estatales adicionales por incapacidad cuando se terminan los beneficios por incapacidad total temporal (TTD, por sus siglas en inglés), o cuando estos se demoran o los deniegan.

Beneficios por incapacidad permanente: Pagos si su lesión causa una incapacidad permanente. Una vez que su lesión se estabilice, es posible que el médico que lo trata determine que usted tiene una incapacidad permanente, dependiendo de su grado de recuperación. La cantidad de incapacidad permanente que su médico determine será clasificada por su administrador de reclamaciones según su edad y ocupación con el fin de determinar el porcentaje y la cantidad correspondiente en dólares que se le debe a usted a causa de la incapacidad permanente. La ley estatal establece dichas cantidades. Usted tiene derecho a obtener una clasificación estatal de incapacidad o a apelar la clasificación.

Programa para reintegrarse al trabajo: Si usted sufre la pérdida permanente de sus ingresos como resultado de su lesión y se determina que sus beneficios por incapacidad permanente son desproporcionadamente bajos, es posible que usted califique para recibir dinero adicional del Fondo para la reintegración al trabajo del Departamento de Relaciones Laborales (Department of Industrial Relations). Comuníquese con el Departamento de Relaciones Laborales en: www.dir.ca.gov/ para conocer más acerca de este beneficio adicional.

Vales suplementarios por destitución laboral: Si su lesión conlleva a que usted falte a su trabajo y le causa una incapacidad permanente, usted puede recibir un vale suplementario por destitución laboral si su empleador no le ofrece un empleo modificado, alternativo o regular dentro de 60 días de haber recibido el informe médico que indique que usted logró una recuperación médica máxima. El vale es para reembolsar los costos educativos y tiene un límite de \$6,000.00. Si usted recibe un vale como consecuencia de su lesión, tiene dos años desde la fecha en que le proporcionen el vale o cinco años desde la fecha de su lesión (lo que ocurra último), para solicitar el reembolso de los gastos que califiquen.

Beneficios por muerte: Se pagan a los dependientes de un trabajador que muere a causa de una lesión o enfermedad laboral. También se cubren los gastos del entierro; la cantidad máxima permitida depende de la fecha de la lesión.

Los beneficios por incapacidad temporal, incapacidad permanente y muerte se pagan a una tasa basada en 2/3 de su salario semanal promedio, y están sujetos a las cantidades mínimas y máximas vigentes en el estado en la fecha de su lesión. Estos beneficios se pagan cada dos semanas mientras usted sea elegible.

Es posible que las actividades como voluntario, en sus horas libres, recreacionales, sociales o atléticas no estén cubiertas bajo la compensación laboral.

Si se lastima:

Obtenga atención médica. Si necesita primeros auxilios, comuníquese con su empleador. Si necesita atención urgente, pida ayuda de inmediato.

Informe sobre su lesión. Informe de inmediato a su supervisor sobre su lesión. No demore en hacerlo; existen límites de tiempo. Si espera demasiado, puede perder los derechos que tiene a recibir beneficios. Su empleador tiene que proporcionarle un formulario de reclamación a más tardar un día laborable después de que esté enterado de su lesión, y también debe autorizar el tratamiento a más tardar un día laborable después de que usted le entregue una copia del formulario lleno y firmado. El plazo de prescripción para presentar una reclamación de compensación laboral es de un año a partir de la fecha de la lesión o, si esta se debe a exposiciones repetidas, un año a partir del momento en que usted se dio cuenta o debió darse cuenta de que su trabajo causó la lesión.

Vea a su médico tratante. Su médico tratante primario es el médico con la responsabilidad global de tratar su lesión o enfermedad. Él o ella están a cargo de mantener la continuidad de su atención, así como de remitirlo a los especialistas. Si su empleador tiene una Red de Proveedores Médicos (MPN, por sus siglas en inglés) aprobada, es posible que ellos puedan limitar sus opciones de médicos tratantes, que retengan el control médico, y que le exijan que se atienda con un médico de la MPN desde el principio. (Una MPN es una red escogida de proveedores de atención médica que proveen tratamiento a los empleados que se lesionan en el trabajo. Consulte con su empleador para obtener más información sobre su MPN). De lo contrario, su empleador tiene el derecho de escoger el médico que lo tratará a usted por los primeros 30 días. Si su empleador no tiene una MPN aprobada y usted desea cambiar de médico en los primeros 30 días después de presentar su reclamación, su administrador de reclamaciones debe escoger un médico nuevo en un lapso de cinco días después de que usted lo solicite.

Si usted le proporcionó a su empleador el nombre de su médico personal antes de sufrir la lesión y tiene seguro médico de grupo al momento de la lesión, usted puede tratarse con su médico personal incluso si su empleador tiene una MPN aprobada. Su médico personal debe ser un médico general o un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, o un grupo médico con múltiples especialidades con doctores o licenciados en medicina, y debe haberlo tratado y tener sus antecedentes médicos y su historia clínica antes de su lesión laboral y también debe estar de acuerdo en tratarlo por una lesión o enfermedad laboral. Si su empleador no tiene una MPN aprobada y usted le dio a su empleador por escrito el nombre de su quiropráctico o acupunturista personal antes de sufrir la lesión, usted puede cambiarse al quiropráctico o acupunturista cuando lo solicite. Si todavía necesita recibir atención médica luego de 30 días, quizás pueda cambiarse a un médico de su propia elección.

Para mayor comodidad, se adjuntan a este documento formularios opcionales para predesignar a su médico personal o a un grupo médico con múltiples especialidades con doctores o licenciados en medicina. También se adjuntan formularios para predesignar a su acupunturista o quiropráctico personal si su empleador no cuenta con una red de proveedores médicos. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

Discriminación: Es ilegal que su empleador lo castigue o lo despida por sufrir una lesión o enfermedad laboral, por presentar una reclamación, o por testificar en el caso de compensación laboral de otra persona. Si se determina que su empleador ha cometido discriminación, usted puede tener derecho a que se le reincorpore a su puesto de trabajo con pagos retroactivos, una mayor compensación, y costos y gastos. Es posible que usted tenga otros derechos bajo la Ley de Protección para Personas Discapacitadas (ADA, por sus siglas en inglés) o la Ley de Igualdad en el Empleo y la Vivienda (FEHA, por sus siglas en inglés). Para obtener más información, comuníquese con FEHA al (800) 884-1684 o con la Comisión de Igualdad de Oportunidades Laborales (EEOC,

por sus siglas en inglés) al (800) 669-3362. Puede obtener información gratuita de un funcionario de información y ayuda de la División de Compensación Laboral de su estado. Puede escuchar información grabada y una lista de las oficinas locales llamando sin costo al **(800) 736-7401** o averiguar más en línea en: <http://www.dir.ca.gov>.

Si su empleador no le proporciona atención médica, usted tiene varias opciones. Primero, comuníquese con su administrador de reclamaciones para averiguar el estado de su reclamación. Si le entregó a su empleador un formulario de reclamación lleno y firmado pero su reclamación está retrasada por la investigación, su empleador tiene que autorizar el tratamiento, hasta un máximo de \$10,000.00, durante el retraso. Si todavía no se ha aceptado la reclamación y sus costos médicos sobrepasan el límite reglamentario de \$10,000.00, usted puede acudir a su plan médico de grupo para recibir atención, buscar un médico, una clínica o un hospital que le facture directamente al administrador de reclamaciones, o utilizar los servicios públicos de atención médica.

Usted tiene derecho a estar en desacuerdo con las decisiones que afectan su reclamación. Si está en desacuerdo, comuníquese primero con su administrador de reclamaciones para ver si lo pueden resolver.

Su compañía de seguros de compensación laboral es **Travelers Property Casualty Company of America**.

También puede buscar su compañía de seguros en el directorio en línea de WCIRB: <https://www.caworkcompcovrage.com/>

Puede obtener información gratuita de un funcionario de Información y Ayuda de la División de Compensación Laboral de su estado, o puede escuchar información grabada y una lista de las oficinas locales llamando al (800) 736-7401. Al final de este folleto, encontrará una lista de las oficinas de Información y Ayuda. Esto lo ayudará a localizar la oficina más cerca de usted. Para más información, también puede visitar el sitio web del DWC en: <http://www.dir.ca.gov>.

Puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar un abogado, es posible que los honorarios se saquen de algunos de sus beneficios. Para obtener los nombres de los abogados especializados en compensación laboral, llame al Colegio de Abogados del estado de California al (415) 538-2120 o visite su sitio web en: <http://www.californiaspecialist.org>. El funcionario local de información y ayuda puede proporcionarle una lista de los abogados o usted puede buscarlos en las páginas amarillas.

Predesignación del médico personal

En caso de que sufra una lesión o enfermedad relacionada con su empleo, su médico (doctor (M.D.) o licenciado (D.O.) en medicina) personal o grupo médico pueden atenderlo si:

- usted tiene cobertura médica de grupo al momento de la lesión;
- el médico es su médico habitual, y debe ser un médico cuyo ejercicio de la medicina se limita a medicina general o que es un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, y que anteriormente haya estado a cargo de su tratamiento médico y tenga en su poder su historia clínica;
- su "médico personal" puede ser un grupo médico si se trata de una corporación con un solo miembro o una sociedad constituida por doctores o licenciados en medicina, que opere un grupo médico integrado con múltiples especialidades que brinde servicios médicos integrales predominantemente para enfermedades y lesiones que no sean de tipo laboral;
- antes de la lesión, su médico acepta tratarlo por lesiones o enfermedades laborales;
- antes de la lesión, usted le proporcionó a su empleador lo siguiente por escrito: (1) notificación de que usted desea que su médico personal lo trate por lesiones o enfermedades laborales, y (2) el nombre y la dirección del consultorio de su médico personal.

Puede usar este formulario para notificar a su empleador si desea que su médico o licenciado en medicina personal lo trate por una lesión o enfermedad laboral, siempre que se cumplan los requisitos anteriores.

Notificación de predesignación del médico personal

Empleado: Llene esta sección.

Para: _____ (nombre del empleador) Si sufro una lesión o enfermedad laboral, escojo ser atendido por:

(Nombre del médico, doctor en medicina, licenciado en medicina o grupo médico)

(Dirección, ciudad, estado, código postal)

(Número de teléfono)

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Firma del empleado _____ Fecha: _____

Médico: Estoy de acuerdo con esta predesignación.

Firma: _____ Fecha: _____

(Médico o empleado designado del médico o del grupo médico)

No se requiere que el médico firme este formulario, sin embargo, si el médico o el empleado designado del médico o del grupo médico no firma, se necesitará otra documentación de la aceptación del médico a ser predesignado, conforme al Capítulo 8, Código de Disposiciones Reglamentarias de California, apartado 9780.1(a)(3).

Notificación de quiopráctico personal o acupunturista personal

Si su empleador o la compañía de seguros de su empleador no tienen una Red de Proveedores Médicos, usted quizás pueda cambiar su médico tratante a su quiopráctico o acupunturista personal después de una lesión o enfermedad laboral. Para cumplir los requisitos para hacer este cambio, debe proporcionarle a su empleador, por escrito, el nombre y la dirección del consultorio de un quiopráctico o acupunturista personal antes de que ocurra la lesión o enfermedad. Por lo general, su administrador de reclamaciones tiene el derecho de escoger su médico tratante dentro de los primeros 30 días después de que su empleador esté enterado de su lesión o enfermedad. Luego de que su administrador de reclamaciones inicie su tratamiento con otro médico durante este período, usted podrá, previa solicitud, hacer que transfieran su tratamiento a su quiopráctico o acupunturista personal.

Usted puede utilizar este formulario para notificar a su empleador acerca de su quiopráctico o acupunturista personal. Por ley, no se permite que los quioprácticos sean el médico tratante luego de 24 visitas.

Información de su quiopráctico o acupunturista:

(Nombre del quiopráctico o acupunturista)

(Dirección, ciudad, estado, código postal)

(Número de teléfono)

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Firma del empleado _____ Fecha: _____

Comuníquese con la unidad de información y ayuda

- Por teléfono al 1-800-736-7401: Para obtener información grabada que ayuda a los trabajadores lesionados, los empleadores y otras personas a entender el sistema de compensación laboral de California, y sus derechos y responsabilidades conforme a la ley.
- Asistiendo a un taller para trabajadores lesionados
- Llamando o yendo en persona a una oficina local de la Unidad de información y ayuda:

Anaheim 1065 N. PacifiCenter Drive Anaheim 92806 (714) 414-1801	Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	San Diego 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	Oxnard 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	San Francisco 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	Pomona 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	San Jose 100 Paseo de San Antonio, Room 241 San Jose, CA 95113-1402 (408) 277-1292
Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	Redding 2115 Civic Center Drive Room 15 Redding, CA 96001-2796 (530) 225-2047	San Luis Obispo 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
Goleta 6755 Hollister Avenue, Room 100 Goleta, CA 93117-5551 (805) 968-4158	Riverside 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	Santa Ana 605 W Santa Ana Blvd, Bldg 28 Room 451 Santa Ana, CA 92701 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	Sacramento 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	Santa Rosa 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	Salinas 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	Stockton 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Marina del Rey 4720 Lincoln Blvd 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	San Bernardino 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	Van Nuys 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

POLICYHOLDER NOTICE

JANUARY 1, 2014 AUDIT REQUIREMENTS FOR POLICIES WITH FINAL PREMIUM OF LESS THAN \$10,000 THAT DEVELOP PAYROLL IN HIGH WAGE DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

If your policy effective on or after January 1, 2014 produces a final premium of less than \$10,000 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. If your policy produces a final premium of \$10,000 or more, a physical audit is required at least once a year.

A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

STATE OF CALIFORNIA
IMPORTANT LOSS CONTROL INFORMATION

The Loss Control Services outlined in the enclosed Safety Services notice are available at no additional cost to you.

Workers' Compensation insurance policyholders may register comments about the insurer's loss control consultation services by writing to: State of California, Department of Industrial Relations, Division of Occupational Safety and Health, P.O. Box 420603, San Francisco, CA 94142.

POLICYHOLDER NOTICE

PAYROLL RECORD AND AUDIT REQUIREMENTS FOR DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Your policy includes one or more construction or erection classifications. Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

Payroll Record Requirements

The assignment of a high wage classification to any non-salaried employee is contingent on verifying that employee's hourly wage by reconciling the total number of hours the employee actually worked throughout the policy period against the employee's time cards or time sheets that document the operations performed, the daily start and stop times and the total hours worked each day for that employee. Recording the start and stop times for a uniform unpaid meal period at job locations where all operations cease for the uniform break period is not required.

The non-salaried employee's regular hourly wage shall be determined by dividing that employee's total remuneration by the hours worked, irrespective of whether the employee is paid on an hourly, piecework, production or commission basis.

The payroll earned by any non-salaried employees for whom we are unable to verify the total number of hours worked will be assigned to the low wage classification that describes the operations performed. The regular hourly wage of salaried employees is determined by dividing the total annual remuneration by 2000 hours. If an employee is salaried for less than 12 months, the regular hourly wage for the salaried period is calculated on a prorated basis.

Audit Requirements

If your policy produces a final premium of \$10,000 or more, a physical audit is required at least once a year. If your policy produces a final premium of less than \$10,000 and payroll is developed under a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

If you hold a C-39 Roofing Contractor license from the California Contractors State License Board, a physical audit is required on the complete policy period of each policy regardless of the amount of final premium.

COLORADO RISK MODIFICATION PLANS

PREMIUM CREDIT FOR EMPLOYING PREVIOUSLY INJURED EMPLOYEES WITH PERMANENT PARTIAL DISABILITIES

Effective March 1, 1993 Colorado Regulation 5-1-11 provides criteria for the modification of manual rates Workers Compensation.

One section of the Regulation provides for a premium credit for all employers who rehire injured employees.

The credit applies to the premium developed from the payroll of rehired injured employees who sustained permanent partial disabilities. (Does not apply to minimum premium policies.)

The Regulation defines a rehired employee with permanent partial disabilities as one "Who sustained permanent partial disabilities and is re-employed by the same employer, not a successor, at the pre-injury wages, including any wage increases to which such employee would have been entitled had the employee not been injured.

If any employee is rehired during a policy period the rehired employee shall be considered as being rehired for the total annual policy period or term.

If you have any employees who are in this category, please indicate the information below and return this to your agent or broker. Upon receipt of this information the payrolls will be verified at final audit and your policy will be adjusted to show any credit.

EMPLOYEE NAME	PAYROLL	POLICY PERIOD	DATE INJURED	DATE REHired	CLASS CODE
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**TOTAL NUMBER OF EMPLOYEES WHO SUSTAINED
PERMANENT PARTIAL DISABILITIES** _____
(During the policy term)

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

**Workers Compensation
Acknowledgement Form:**

POLICY NUMBER: (TRJUB-4246B09-2-14)

POLICY EFFECTIVE DATE: 04-01-14

IMPORTANT MESSAGE TO INSUREDS

ACKNOWLEDGEMENT FORM REQUIREMENTS

Dear Insured:

Colorado Insurance Regulation 5-1-11, Risk Modification Plans, allows premium credits to employers who have IMPLEMENTED Certified Workers Compensation Risk Management Programs.

Premium credits for eligible employers are to be applied by the attachment of endorsement WC 05 04 03 (00) to the policy. The Colorado Workers Compensation Cost Containment Board has determined that a premium differential shall be provided on all policies when you have selected a Designated Medical Provider.

In order to obtain the premium credit you – the Employer – must complete and sign the bottom portion of this form with the requested information. Retain a copy for your records and send your agent or producer a copy. Your agent or producer will forward a copy to your Insurer. An endorsement, will then be attached to your policy to reflect the credit.

For a complete explanation of how these programs operate and the savings, please contact your agent or producer.

- I have implemented a Certified Workers Compensation Risk Management Program**
- I have NOT implemented a Certified Workers Compensation Risk Management Program**
- I have selected a Designated Medical Provider. Indicate who the Provider is below.****

PROVIDER: _____

- I have NOT selected a Designated Medical Provider.**

**** A copy of your Workers Compensation *Colorado Premium Cost Containment Certificate* must be forwarded to your Insurer.**

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

FLORIDA

Workers Compensation

Managed Care

Arrangement

Handbook

Inside:

- Employer/Employee Implementation Guides
- Program Explanation for Employees
- Employee Questions and Answers
- Employee Satisfaction Survey
- Employee Rights & Responsibilities and Grievance Policy
- Acknowledgment Form

Employee Rights & Responsibilities and the Grievance Policy and Grievance form are to be shared with each employee. The other informative materials can be used at your discretion.

Florida Workers Compensation Managed Care Arrangement

To our Employers:

Thank you for taking an active role in helping manage your Workers Compensation exposures. The enclosed information is designed to give you basic knowledge of your Workers Compensation Managed Care Arrangement ("WC/MCA"). By taking an active role in ensuring the use of the WC/MCA, you may be able to expedite medical recovery for your injured employees and reduce lost time days.

Your Carrier/Claim Administrator has contracted with Coventry Health Care Workers' Compensation, Inc. for the use of their Coventry Integrated Network ("Network") of medical providers to ensure high quality medical care related to workers compensation claims. Providers within the Network are experienced in Workers Compensation, and have contractually agreed to comply with Florida Workers Compensation Law.

To maximize the benefits of the WC/MCA, pre-injury preparation should include the following:

1. Identify which Network PCPs are available near your work-site by reviewing the on-line directory. (The Network search engine is available through www.travelers.com or www.mywcinfo.com)
2. Select one or more of the nearby PCPs and initiate a working relationship with them. Doing so in advance will make it quick and easy to refer an Employee should a work-site injury occur. Consider posting the list of PCPs (with addresses and phone numbers) in a location easily accessible to those employees who will use it should an injury occur.
3. Make your staff familiar with the provider listings and explain how easy it is to use providers in the Network Directory.
4. Advise the staff that use of the network providers is mandatory except in emergency situations. The providers participating in the Network meet specific quality standards and credentials and are experienced in treating work-related injuries and illnesses.
5. For employees who have Internet access, use of the www.mywcinfo.com web page can provide additional access to selection of network providers. However, employees need to know that only treatment that is authorized by the carrier will be compensable in the Workers Compensation claim.
6. It is in everyone's best interest to return your Employee to the job as soon as it is medically appropriate. The availability of modified and/or transitional duty programs at the work-site is key to this approach. Designate a company employee to serve as your Workers Compensation Coordinator and develop a transitional duty program.

To assist with implementation of the WC/MCA, this packet includes the following materials for your use:

1. How to Locate a Network Primary Care Provider on the Travelers' Internet Site
2. What To Do When An Employee Reports An Injury
3. Request For Medical Treatment Form
4. Sample Letter To The Employee
5. Questions and Answers for Employees
6. Employee Satisfaction Survey
7. Employees Rights & Responsibilities
8. Employee Grievance Procedure

If you have any questions concerning the enclosed materials, or if additional resources are needed, please do not hesitate to call the Managed Care Administrator at 1-800-842-6771. Your active role can produce better outcomes for everyone involved in the Workers Compensation process.

Florida Workers Compensation Managed Care Arrangement

How To Locate a Network Primary Care Provider on the Travelers Internet Site

Travelers Internet site is: www.travelers.com

Select:

- "Workers Comp Claim Resources" under Claim
- "Find a Network Medical Provider" under Workers Comp Claim Resources

You are now in the Workers Compensation Network provider search engine:

- Select "Provider Search"

A screen appears that allows you to set your search parameters

- Enter the zip code for the usual employment site for the employee/employer
- Select the mileage range, up to 20 miles for Primary Care Physicians
- Allow the "Sort Results By" category to remain set at "Distance"
- Select the Number of provider matches you would like to see on each page
- Click on "Continue"
- On the new screen, click on/highlight the "Provider Types" and/or "Specialties" you would like to include in the search
- Click on "Find Providers"
- Scroll down the page to find a list of Network providers. Depending on the geographic distance, there may be several pages of physicians provided.

You can generate a printed list or directory of Network physicians using several methods:

- At the end of the page, click on "Create Provider Listing" button. This will create a listing of all the providers on that page.
- At the end of the list of physicians on a given page there are 2 buttons. Click on "Select all providers on this page." A check mark will appear before all providers. Click on the "Create Provider Listing" button and a directory will be generated.
- If you would like a short list of physicians/providers, click in the box before each provider you would like to select on that page. Then click on "Create Provider Listing" and a list of your selected physicians will be available for printing.
- A directory for the entire state of Florida can be obtained by clicking on the tab at the top of the screen, labeled "Directories."

More about the provider database:

- Obtain additional information about a specific provider by clicking on the map icon. You will find more information about the provider, a location map and a tool to gain driving instructions.

Florida Workers Compensation Managed Care Arrangement

WHAT TO DO WHEN AN EMPLOYEE REPORTS AN INJURY

When emergency medical attention is required, send the injured employee to the nearest medical facility and contact the telephone reporting center at 1-800-832-7839 to report the claim.

When an employee reports an injury not requiring emergency treatment, the following steps should be observed:

1. GATHER INFORMATION REGARDING THE INJURY

Ask the injured employee how, when and where the injury occurred, and if there were any witnesses.

2. CONTACT TELEPHONE REPORTING CENTER AT 1-800-832-7839 TO REPORT THE CLAIM

Upon direction from the Claim Adjuster, send the injured employee for medical treatment. Remember: If this is a medical emergency, direct the employee to seek medical attention immediately and then follow-up with this call.

3. DIRECT THE INJURED EMPLOYEE TO CHOOSE A PRIMARY CARE PHYSICIAN.

In non-emergency situations, if the employee appears to need medical attention, either direct the employee to the Network Primary Care Physician ("PCP") of your choice, or instruct the employee to choose a PCP from your list of providers within the Coventry Integrated Network ("Network"). All medical care must be provided through the authorized Primary Care Physician in order to ensure workers Compensation benefits. (A Medical Care Coordinator will be assigned by the Claim Adjuster after the employee's injury has been diagnosed.)

4. COMPLETE AN EMPLOYEE INTRODUCTION LETTER

Fill in a copy of the Request For Medical Treatment Form with the appropriate information. Give the completed Request for Medical Treatment Form to the injured employee and advise him/her to give the letter to the provider he/she has chosen as his/her PCP before treatment is initiated.

5. ARRANGE FOR THE EMPLOYEE TO BE TREATED BY A PROVIDER WITHIN THE NETWORK

Either you, the Medical Case Manager or the Claim Adjuster should contact the PCP to confirm authorization of an appointment for treatment of the injured employee.

6. FOLLOW-UP AND RETURN-TO-WORK

Obtain the DWC25 form (completed by the physician) from either the injured employee or the physician's office. Work with the assigned Claim Adjuster/Medical Case Manager and the PCP to return the employee to either light or full duty. Evaluate any restrictions and offer modified duty if applicable.

Florida Workers Compensation Managed Care Arrangement

**THE WORKERS COMPENSATION MANAGED CARE ARRANGEMENT
REQUEST FOR MEDICAL TREATMENT FORM**

Part 1: (To be completed by Supervisor. Please Print.)

Employee Name: _____ Social Security Number: _____

Date: _____ Supervisor Name: _____

Employer Name: _____ Supervisor Phone Number: _____

Employer Address: _____

Date of Injury: _____ Place of Injury: _____

Injury Description: _____

Part 2: (To be completed by Employee. Employee should take this form to the Primary Care Physician or treating physician.)

English: I authorize payment directly to the provider for the medical services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designee for medical review.

Spanish: Autorizo a que se efectúe el pago directamente al proveedor por los servicios médicos prestados, y autorizo la divulgación de información médica a la Compañía de Seguros / Administrador de Reclamaciones o a la persona designada para la revisión médica.

Creole: Mwen bay otorizasyon pou fè peman dirèk bay moun ki fè sèvis medikal pou mwen, epi mwen bay otorizasyon pou yo bay Administratè Swen Sante a/ Responsab pou Reklamasyon an, oswa moun yo nonmen pou sa, enfòmasyon medikal sou mwen, pou yo gade dosye sante m.

Employee Signature: _____ Date: _____

***Note* By providing this form to the Employee, neither the Carrier/Claim Administrator nor the Employer concede compensability or eligibility of the injury described above under the applicable Workers Compensation laws.**

Part 3: Report Work Status by completing the DWC25 (To be completed by Primary Care Physician or treating physician. Please print.)

The physician should complete the DWC25 form, give one copy to the Employee (to return to the Employer), attach one copy to your itemized bill and medical report being sent to the Carrier/Claim Administrator, and keep third copy for your records.

You can obtain a copy of the DWC25 form by calling 1-800-842-6771 and requesting the form from the Claim Adjuster. Or, the Florida Division of Workers' Compensation provides an on line interactive process for completion of the DWC25. You can access the form through the following steps:

- Web page for DWC: www.fldfs.com/wc/forms.html
- Select the tab for 69L-7. The DWC 25 forms can be found on this page.

Florida Workers Compensation Managed Care Arrangement

Part 4: (Important information for Medical Providers)

This Employer is covered by a Workers Compensation Managed Care Arrangement that utilizes a Network of Medical Providers. If medical care for the Employee requires referral to a specialist, the Carrier/Claim Administrator will consult the Network Directory for the name of a Network Specialist.

Please Contact the Claim Adjuster or the Medical Case Manager at 1-800-842-6771 upon any of the following:

- Need for authorization of diagnostic studies, DME, or specialty referrals
- Hospital and inpatient facility admission;
- Outpatient knee, back, wrist, or shoulder surgery;
- Physical therapy or chiropractic care (within the first six months of injury or newly initiated, e.g., post surgical);
- Anticipated disability greater than seven days without a reasonable RTW date established (within the first six months of injury or date of disability);
- Services, which require utilization management pursuant to state law or regulation.

Part 5 (Claim Information)

1. The Florida Division of Workers' Compensation now requires completion of a DWC25 form at specific time frames, such as each date of service. Please be sure that the employer and carrier receive the completed form as promptly as possible after each appointment so that timely treatment and appropriate RTW can be facilitated. For more information about the form, please contact the Claim Adjuster using 1-800-842-6771 or the DWC web page provided earlier.
2. Print the Employee's social security number and date of injury on any bills and reports. Bill only for services directly related to the work injury and submit an itemized bill and medical report, along with the completed DWC25, to the claim office.
3. Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers Compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both, imposed pursuant to applicable statutes and/or regulations.

Florida Workers Compensation Managed Care Arrangement

Dear Employee:

For compensable workers compensation claims, your employer provides medical care through its Workers Compensation Managed Care Arrangement ("WC/MCA").

Although everyone is committed to promoting a safe and healthy work environment, work-related illnesses and accidents can occur. In order to provide you with the best possible medical care, should a work-related illness or accident occur, your employer has implemented the Workers Compensation Managed Care Arrangement. This Arrangement includes an independent network of preferred providers available through the Coventry Integrated Network ("Network").

The Network offers many benefits including the following:

- Primary Care Physicians and medical specialty physicians
- Network Providers are credentialed to stringent standards and criteria
- Providers within the Network are experienced in treating work-related injuries and want to aid in your return-to-work when medically appropriate.

Except in emergency situations and other specific circumstances, you must obtain medical care from a Primary Care Physician within the Network in order to receive full workers compensation benefits. Your employer is prepared to assist you in accessing/selecting a Primary Care Physician who is part of the Network.

The WC/MCA promotes a team approach to treating workers compensation injuries. The team includes you, your employer, your Primary Care Physician (PCP) and/or Medical Care Coordinator (MCC), your Claim Adjuster and your Medical Case Manager. This approach provides timely, appropriate and efficient medical treatment for you and a timely return-to-work. Everyone benefits from this partnership.

Since we anticipate that you may have some questions regarding the Workers Compensation Managed Care Arrangement, we have prepared the attached reference materials.

Florida Workers Compensation Managed Care Arrangement

Estimado Empleado:

Para las reclamaciones de compensación legal por accidentes de trabajo que sean compensables, su empleador proporciona cuidados médicos a través de su Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo ("WC/MCA", por sus siglas en inglés).

A pesar de que todos estamos comprometidos a fomentar un ambiente de trabajo saludable y en el que no haya riesgos, es posible que surjan enfermedades y ocurran accidentes relacionados con el trabajo. Para proporcionarle los mejores cuidados médicos posibles, en caso de que contraiga una enfermedad o sufra un accidente relacionado con el trabajo, su empleador ha implementado el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo. Este Convenio incluye una red independiente de proveedores preferidos disponible a través de la Red Coventry Integrated (la "Red").

La Red ofrece muchos beneficios, entre los que se incluyen los siguientes:

- Médicos de cabecera (PCP) y médicos especialistas
- Los Proveedores de la Red cuentan con acreditaciones obtenidas conforme a estrictas normas y criterios
- Los proveedores de la Red tienen experiencia en el tratamiento de lesiones relacionadas con el trabajo y desean prestarle ayuda para que se reincorpore al trabajo cuando sea apropiado desde el punto de vista médico.

Excepto en situaciones de emergencia y en otras circunstancias específicas, usted debe recibir cuidados médicos provenientes de un Médico de cabecera (PCP) de la Red para obtener la totalidad de los beneficios de compensación legal por accidentes de trabajo. Su empleador está preparado para ayudarle a acceder/seleccionar un médico de cabecera que pertenezca a la Red.

El convenio WC/MCA promueve un enfoque en equipo para el tratamiento de las lesiones cubiertas por la compensación legal por accidentes de trabajo. En el equipo están incluidos usted, su empleador, su médico de cabecera (PCP) y/o el Coordinador de Cuidados Médicos (MCC), su Tasador de Reclamaciones y su Gestor de Casos Médicos. Este enfoque le proporciona un tratamiento médico oportuno, adecuado y eficaz para que pueda regresar al trabajo oportunamente. Todos se benefician de esta asociación.

Como prevemos que puede tener algunas preguntas relacionadas con el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo, hemos preparado los materiales de referencia que se adjuntan.

Florida Workers Compensation Managed Care Arrangement

Questions & Answers The Workers Compensation Managed Care Arrangement

1. Goal of Managed Care Arrangement	<p>A. Ensure provision of prompt, high quality medical care with Network physicians following a work related injury</p> <p>B. Facilitate returning to work as soon as medically possible.</p>		
2. What is a Managed Care Arrangement?	<p>A plan approved by the State of Florida for providing timely medical care through a partnership of the following participants:</p>	Participant	Role in Your Claim
		Network physicians	<ul style="list-style-type: none"> • Diagnose and Treat your work related injuries and make referrals to network specialty care as needed • Coordinate return to work with your employer
		Employers	<ul style="list-style-type: none"> • Develop transitional duty program • Ensure timely treatment following an injury • Facilitate return to work as soon as medically feasible
		Carrier Claims Adjuster and Medical Case Manager	<ul style="list-style-type: none"> • Contact you to discuss your accident and injury • Ensure you receive necessary treatment • Coordinate referrals and initial appointments with network providers • Answer questions about the WCMCA • Work with you, your employer and provider to facilitate return to work
		Injured Employee	<ul style="list-style-type: none"> • Report injury as promptly as possible • Participate in treatment as ordered by authorized physician • Keep employer informed about work status and restrictions • Return to Work when recommended by physician and accommodated by employer • Discuss any problems or concerns with carrier
3. Is use of WC/MCA mandatory?	<p>Yes. Only treatment provided by authorized network physicians will be compensable. Failure to follow treatment recommendations from authorized physicians may impact your claim benefits.</p>		
4. What if I need emergency treatment after an accident?	<p>You will treat at the nearest hospital or appropriate facility. Treatment will be authorized and bills will be paid. When you no longer require emergency treatment, you will be sent to a Network Primary Care Physician (PCP) for continued care.</p>		
5. Where do I go if I do not need emergency treatment?	<p>Your employer will either direct you to a physician/clinic for initial medical care, or will provide you with a list of physicians/clinics from whom you may choose your initial treating Network physician. All compensable treatment must be with a Network physician authorized by your employer or the carrier before treatment begins. Many network Primary Care Physicians are conveniently located 15-30 miles from your work-site, and many specialists are 30-60 miles from your work-site.</p>		
6. What do I do when I am working for my employer outside my area and need to see a doctor?	<ul style="list-style-type: none"> • If the injury is not an emergency, contact your employer for directions. You will be provided with a local treatment center in that area and will be referred to a physician in Network when you return to your service area, if further treatment is needed. • If it is an emergency situation, seek immediate medical attention at the nearest hospital or facility. 		

Florida Workers Compensation Managed Care Arrangement

7. How can I find network physicians in my area?	The names, addresses and phone numbers of Primary Care Physicians have been posted by your employer. If you do not know where the list has been posted, ask your employer for the location. If you have access to the Internet, selecting "Locate Network Medical Providers" on the www.mywcinfo.com webpage will also take you to the list of network providers.
8. What is a Primary Care Physician (PCP) and what does the PCP do?	The Primary Care Physician is a network physician licensed as a family practitioner, general practitioner, occupational medicine, occupational/urgent clinic, internist or osteopath (or other physician which your Medical Case Manager or Claim Adjuster agrees is appropriate to treat your injury). The Primary Care Physician is responsible for providing evaluation and treatment of your work related injury.
9. What is a Medical Care Coordinator (MCC) and what does the MCC do?	The Medical Care Coordinator (MCC) is a licensed network physician who serves as the "gate keeper" for medical issues related to your work injury. The MCC will help make final medical decisions in your workers compensation claim. You will probably be examined at least one time to evaluate your work injury, treatment needs and return to work needs. The MCC may or may not be your treating physician. Once assigned to your claim, the MCC probably will not change during the length of your claim. If you have specific concerns about your medical care, you can discuss them directly with the MCC.
10. What if the PCP decides I need to see a specialist (such as an orthopedist)?	If you would like to see a specialist, gain a referral from the authorized physician in your claim. All specialty referrals must be made by network physicians already authorized to provide you with treatment. Following receipt of a referral, the Claims Adjuster or Medical Case Manager will direct you to an orthopedic surgeon or other specialist within the Network. Before the first appointment with a new physician, authorization must be gained from the Claims Adjuster or Medical Case Manager.
11. What if I am not happy with my physician or the treatment plan for my work injury?	Contact the Medical Case Manager and/or Claim Adjuster to discuss your options. <ul style="list-style-type: none"> • Florida Workers Compensation law allows for one change in provider during the life of your claim. All changes must be made to network physicians in the same specialty and you cannot change physicians without prior authorization. Your Medical Case Manager or Claims Adjuster will make the necessary arrangements for any change in network physician. You may be able to select a new network physician from a list provided by the Claims Adjuster only if authorization of the new physician is not provided within 5 days of receipt of your written request for the one time change in physician. • A second opinion may be possible if there is a referral from an authorized physician with documentation that supports the medical necessity of the need for further evaluation.
12. After changing an authorized treating physician, what should I do if I am still dissatisfied?	You should immediately contact your Claim Adjuster or Medical Case Manager and express your concerns and/or dissatisfaction. If you still wish to change your Primary Care Physician or specialist, you must follow the formal grievance process (please refer to the document entitled "Grievance Procedure" attached to this document).
13. What is an Independent Medical Examination (IME)?	Once, during the life of your workers compensation claim, if there is a major disagreement with the medical recommendations from an authorized treating network physician, the injured employee and the carrier/claim administrator each have the right to gain another medical opinion through an Independent Medical Examination (IME). The carrier/claim administrator will pay for the employee's IME only when a network physician is selected for the opinion, or a decision is made to authorize the treatment recommended in the IME report. An IME physician cannot become a treating physician.
14. Who do I contact to file a grievance?	Contact the Grievance Coordinator by phone using 1-800-842-6771 or 800-448-0798 Address: Travelers Workers Compensation Managed Care Arrangement, Attention: Grievance Coordinator P. O. Box 715 Orlando, FL 32802 (Please see the "Grievance Procedure" and Grievance form attached to this document)

Florida Workers Compensation Managed Care Arrangement

Preguntas y Respuestas

El Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo (WC MCA)

1. Objetivos del Convenio de Cuidados Médicos Administrados	<p>A. Garantizar la prestación de cuidados médicos oportunos y de alta calidad con médicos de la Red después de sufrir una lesión relacionada con el trabajo</p> <p>B. Facilitar la reincorporación al trabajo tan pronto como sea posible, desde el punto de vista médico.</p>		
2. ¿Qué es un Convenio de Cuidados Médicos Administrados?	Un plan aprobado por el Estado de Florida que proporciona cuidados médicos oportunos a través de una asociación de los siguientes participantes:	<p>Participante</p> <p>Médicos de la Red</p> <p>Empleadores</p> <p>Tasador de Reclamaciones de la Compañía de Seguros y Gestor de Casos Médicos</p> <p>Empleado Lesionado</p>	<p>Función que desempeña en lo que respecta a su reclamación</p> <ul style="list-style-type: none"> • Diagnóstican y proporcionan tratamiento para sus lesiones relacionadas con el trabajo y están a cargo de los referidos a especialistas de la red, según sea necesario • Coordinan su reincorporación al trabajo junto a su empleador <ul style="list-style-type: none"> • Desarrollan un programa de tareas transitorias • Garantizan el tratamiento oportuno después de sufrir una lesión • Facilitan la reincorporación al trabajo tan pronto como sea posible desde el punto de vista médico <ul style="list-style-type: none"> • Se comunican con usted para hablar sobre su accidente y la lesión sufrida • Se aseguran de que reciba el tratamiento necesario • Coordinan los referidos y las citas iniciales con los proveedores de la red • Responden preguntas sobre el Convenio de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo • Trabajan junto a usted, su empleador y su proveedor para facilitar la reincorporación al trabajo <ul style="list-style-type: none"> • Informa acerca de la lesión lo antes posible • Participa en el tratamiento de la manera indicada por el médico autorizado • Mantiene informado al empleador sobre su condición de trabajo y restricciones relacionadas • Se reincorpora al trabajo cuando así lo indica el médico y según las adaptaciones hechas por el empleador • Habla sobre cualquier tipo de problema o inquietud con la compañía de seguros
3. ¿El uso del WC/MCA es obligatorio?	<p>Sí. Sólo el tratamiento proporcionado por médicos autorizados de la red será compensable. El hecho de no seguir las indicaciones del tratamiento proporcionadas por un médico autorizado puede tener un impacto en los beneficios correspondientes a su reclamación.</p>		
4. ¿Qué sucede si necesito un tratamiento de emergencia después de sufrir un accidente?	<p>Será tratado en el hospital más cercano o en la instalación apropiada. Se autorizará el tratamiento y se pagarán las facturas. Cuando ya no necesite recibir un tratamiento de emergencia, será enviado a un Médico de Cabecera de la Red (PCP) quién se hará cargo de proporcionar los cuidados médicos posteriores.</p>		

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5. ¿Dónde debo ir si no necesito un tratamiento de emergencia?	<p>Su empleador le indicará un médico/clínica a cargo de proporcionarle los cuidados médicos iniciales, o le dará una lista de médicos/clínicas para que usted elija un médico de la red que se hará cargo del tratamiento inicial. Todo tratamiento compensable debe ser proporcionado por un médico de la Red autorizado por su empleador o por la compañía de seguros antes de que se dé inicio al tratamiento. Muchos de los médicos de cabecera de la red se encuentran convenientemente ubicados a una distancia de 15 a 30 millas de su lugar de trabajo, y muchos especialistas a una distancia de 30 a 60 millas de su lugar de trabajo.</p>
6. ¿Qué hago si estoy trabajando para mi empleador fuera de mi área y necesito ver a un médico?	<ul style="list-style-type: none"> • Si la lesión no es una emergencia, comuníquese con su empleador para que le dé instrucciones. Se le proporcionará un centro de tratamiento local en esa área y será referido a un médico de la Red cuando regrese a su área de servicio, si necesita recibir más tratamiento. • Si se trata de una situación de emergencia, busque atención médica de inmediato en el hospital o la instalación más cercanas.
7. ¿Cómo puedo buscar médicos de la red en mi área?	<p>Los nombres, direcciones y números de teléfono de los Médicos de Cabecera han sido colocados por su empleador en un lugar visible. Si no conoce el lugar donde se encuentra la lista, pregúnteselo a su empleador. Si tiene acceso a Internet, seleccione "Locate Network Medical Providers" [Buscar Proveedores de Servicios Médicos de la Red] en la página web www.mywcinfo.com y accederá a la lista de proveedores de la red.</p>
8. ¿Qué es un Médico de Cabecera (PCP) y qué hace un PCP?	<p>El Médico de Cabecera es un médico de la red con licencia para ejercer como médico de familia, médico general, especialista en medicina ocupacional, clínica de medicina ocupacional/de atención de urgencia, especialista en medicina interna u osteópata (u otro médico que su Gestor de Casos Médicos o Tasador de Reclamaciones considere adecuado para el tratamiento de su lesión). El Médico de Cabecera es responsable de hacer la evaluación y proporcionar el tratamiento de su lesión relacionada con el trabajo.</p>
9. ¿Qué es un Coordinador de Cuidados Médicos (MCC) y qué hace un MCC?	<p>El Coordinador de Cuidados Médicos (MCC) es un médico de la red con licencia para ejercer que sirve como coordinador de los problemas de carácter médico asociados a su lesión relacionada con el trabajo. El MCC ayudará a tomar las decisiones médicas definitivas correspondientes a su reclamación de Compensación Legal por Accidentes de Trabajo. Probablemente será examinado al menos una vez para evaluar su lesión relacionada con el trabajo, las necesidades en cuanto a tratamiento y las necesidades en cuanto a su reincorporación al trabajo. El MCC puede o no ser el médico a cargo de su tratamiento. Una vez que haya sido asignado a su reclamación, el MCC probablemente seguirá siendo el mismo durante el tiempo que dure su reclamación. Si tiene inquietudes específicas en cuanto a sus cuidados médicos, puede hablar directamente con el MCC.</p>
10. ¿Qué sucede si el PCP decide que es necesario que yo consulte a un especialista (por ejemplo, a un ortopedista)?	<p>Si usted desea consultar a un especialista, obtenga un referido del médico autorizado de su reclamación. Todos los referidos para ser atendido por especialistas deben ser hechos por médicos de la red que ya tienen autorización para proporcionarle tratamiento. Después de obtener un referido, el Tasador de Reclamaciones o el Gestor de Casos Médicos le derivarán a un cirujano ortopedista o a otro especialista de la red. Antes de la primera cita con un nuevo médico, debe obtener una autorización del Tasador de Reclamaciones o del Gestor de Casos Médicos.</p>
11. ¿Qué sucede si no estoy satisfecho con mi médico o con el plan de tratamiento para mi lesión relacionada con el trabajo?	<p>Comuníquese con el Gestor de Casos Médicos y/o con el Tasador de Reclamaciones para hablar sobre sus opciones.</p> <ul style="list-style-type: none"> • La ley de Compensación Legal por Accidentes de Trabajo de Florida permite un cambio de proveedor durante la vigencia de su reclamación. Todos los cambios deben hacerse a médicos de la red de la misma especialidad y usted no puede cambiar de médico si no cuenta con la autorización previa. Su Gestor de Casos Médicos o Tasador de Reclamaciones hará los arreglos necesarios para efectuar cualquier tipo de cambio a un médico de la red. Usted podrá seleccionar un nuevo médico de la red de una lista proporcionada por el Tasador de Reclamaciones sólo si la autorización para el nuevo médico no es proporcionada dentro de los 5 días posteriores a la recepción de su solicitud por escrito para realizar el cambio del médico de la red por única vez.

Florida Workers Compensation Managed Care Arrangement

	<ul style="list-style-type: none"> • Es posible solicitar una segunda opinión si existe un referido proporcionado por un médico autorizado con documentación que respalde la necesidad médica de que se realicen más exámenes.
12. Despues de cambiar de médico autorizado, ¿qué debo hacer si aún no estoy satisfecho?	Deberá comunicarse de inmediato con su Tasador de Reclamaciones o Gestor de Casos Médicos y expresar sus inquietudes y/o insatisfacción. Si aún desea cambiar de médico de cabecera o médico especialista, debe seguir el proceso de presentación de quejas formales (consulte el documento titulado "Procedimiento de Presentación de Quejas Formales" que se adjunta a este documento).
13. ¿Qué es un Examen Médico Independiente (IME)?	Por única vez, durante la vigencia de su reclamación de Compensación Legal por Accidentes de Trabajo, si existe un desacuerdo importante en lo que respecta a las indicaciones médicas proporcionadas por un médico de la red a cargo del tratamiento, el empleado lesionado y la compañía de seguros/gestor de reclamaciones tienen individualmente el derecho de obtener otra opinión médica a través de un Examen Médico Independiente (IME). La compañía de seguros/el gestor de reclamaciones pagará la IME del empleado sólo cuando se seleccione a un médico de la red para dar la opinión, o bien se tome una decisión para autorizar el tratamiento recomendado en el informe de la IME. El médico a cargo de la IME no puede convertirse en el médico a cargo del tratamiento.
14. ¿Con quién me comunico para presentar una queja formal?	<p>Comuníquese con el Coordinador de Quejas Formales por teléfono llamando al 1-800-842-6771, o al 800-448-0798.</p> <p>Dirección: Travelers Workers Compensation Managed Care Arrangement Attention: Grievance Coordinator P. O. Box 715 Orlando, FL 32802</p> <p>(Lea el "Procedimiento de Presentación de Quejas Formales" y el formulario de Presentación de Queja Formal que se adjuntan a este documento)</p>

Florida Workers Compensation Managed Care Arrangement

THE TRAVELERS WORKERS COMPENSATION MANAGED CARE ARRANGEMENT NETWORK SERVICES

Employee Satisfaction Survey

Our goal is for you to be satisfied with the medical treatment provided during participation in the Travelers Workers Compensation Managed Care Program. We are concerned about the quality of services received from network providers. The form on the following page is a feedback mechanism for expressing the results of medical treatment, both good and bad.

This feedback form is used by Travelers when a specific quality concern has been identified and/or in a random survey process to determine satisfaction with the providers in the workers compensation network.

For the Employee:

If you have been particularly pleased or frustrated by the treatment you received, we will forward a copy of your completed survey to our Managed Care Network, Coventry Integrated Network. Coventry will address the provider concerns you have expressed in your survey. If they have additional questions, a representative from Coventry may contact you directly.

For the Employer: You may want to use this form when an employee expresses:

- Exceptional satisfaction with care that was provided
- Dissatisfaction with care that was provided
- Concerns about the facility/office
- Positive experiences with the facility/office

When an employee is dissatisfied please encourage them to provide their address on the survey in case it is necessary to make contact for additional information.

Florida Workers Compensation Managed Care Arrangement

**THE TRAVELERS WORKERS COMPENSATION
MANAGED CARE ARRANGEMENT INDEPENDENT NETWORK SERVICES**

We want you to be satisfied with the medical treatment you have received as a participant in the Travelers Workers Compensation Managed Care Program. We appreciate your input on the following:

(Name of Provider/Clinic)

(Please circle appropriate choice)

1. Was the clinic or office clean?
 - A. very clean
 - B. somewhat clean
 - C. dirty
 - D. very dirty
2. How long did you wait to be seen by the medical staff?
 - A. less than 20 min.
 - B. 30-45 min.
 - C. 45 min- 1 1/2 hrs.
 - D. over 1 1/2 hrs.
3. Were you treated with care and attention?
 - A. very much so
 - B. careful and attentive
 - C. not so careful or attentive
 - D. very inattentive
4. Did the medical staff explain your diagnosis and/or treatment plan?
 - A. very much so
 - B. explained somewhat
 - C. did not fully cover all issues
 - D. did not explain at all
5. Overall, were you satisfied with your visit?
 - A. very satisfied
 - B. somewhat satisfied
 - C. somewhat dissatisfied
 - D. very dissatisfied

ADDITIONAL COMMENTS: _____

NAME: _____ DATE: _____

ADDRESS: _____ PHONE NUMBER: _____

*****Please return this completed questionnaire to:

The Workers Compensation Managed Care Arrangement
Travelers
P.O. Box 715, Orlando, Florida 32802

Florida Workers Compensation Managed Care Arrangement

SERVICIOS DE LA RED DEL CONVENIO DE CUIDADOS MÉDICOS ADMINISTRADOS DE COMPENSACIÓN LEGAL POR ACCIDENTES DE TRABAJO DE TRAVELERS

Encuesta de Satisfacción del Empleado

Nuestro objetivo es que usted esté satisfecho con el tratamiento médico proporcionado durante la participación en el Programa de Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo de Travelers. Nos preocupamos por los servicios que ha recibido de los proveedores de la red. El formulario de la página siguiente es un mecanismo para brindar comentarios y sugerencias que permite expresar los resultados del tratamiento médico, tanto positivos como negativos.

Este formulario de comentarios y sugerencias es utilizado por Travelers cuando se ha identificado alguna inquietud específica en lo que respecta a la calidad y/o en un proceso aleatorio de encuestas para determinar la satisfacción con los proveedores de la Red de Compensación Legal por Accidentes de Trabajo.

Para el Empleado:

Si se ha sentido particularmente satisfecho o frustrado por el tratamiento que recibió, le enviaremos una copia de la encuesta que ha llenado a nuestra Red de Cuidados Médicos Administrados, Coventry Integrated Network. Coventry abordará las inquietudes en cuanto a los proveedores que usted ha incluido en su encuesta. Si tiene más preguntas, un representante de Coventry puede comunicarse directamente con usted.

Para el Empleador: Puede utilizar este formulario cuando un empleado exprese:

- Una satisfacción excepcional en lo que respecta a los cuidados proporcionados
- Insatisfacción en lo que respecta a los cuidados proporcionados
- Inquietudes sobre la instalación/oficina
- Experiencias positivas en relación con la instalación/consultorio

Cuando un empleado no esté satisfecho, invítelo a incluir su dirección en la encuesta por si es necesario comunicarse con él para obtener más información.

Florida Workers Compensation Managed Care Arrangement

**SERVICIOS DE RED INDEPENDIENTE
DE CONVENIO DE ATENCIÓN MÉDICA DIRIGIDA
DE COMPENSACIÓN LABORAL DE THE TRAVELERS**

Deseamos que usted se sienta satisfecho con el tratamiento médico que ha recibido como participante del Programa de Atención Médica Dirigida de Compensación Laboral de Travelers. Agradeceríamos su información sobre lo siguiente:

(Nombre del Proveedor o Clínica)

(Favor circular la selección adecuada)

1. ¿Estaba limpia la clínica o consulta?
 - A. muy limpia
 - B. más o menos limpia
 - C. sucia
 - D. muy sucia
2. ¿Cuánto tuvo que esperar para que lo vieran los médicos?
 - A. menos de 20 min.
 - B. 30-45 min.
 - C. 45 min- 1 ½ horas
 - D. más de 1 ½ horas
3. ¿Lo trataron con cuidado y atención?
 - A. con mucho cuidado y mucha atención
 - B. con cuidado y atención
 - C. sin tanto cuidado ni atención
 - D. muy desatentamente
4. ¿Le explicaron los médicos su diagnóstico y/o el plan de tratamiento?
 - A. explicaron en detalle
 - B. explicaron en cierta medida
 - C. no cubrieron todas las cuestiones
 - D. no explicaron nada
5. En general, ¿quedó satisfecho con su visita?
 - A. muy satisfecho
 - B. satisfecho en parte
 - C. insatisfecho en parte
 - D. muy insatisfecho

COMENTARIOS ADICIONALES: _____

NOMBRE: _____ FECHA: _____

DIRECCIÓN: _____ TELÉFONO: _____

*****Devuelva este cuestionario debidamente llenado a:

The Workers Compensation Managed Care Arrangement
Travelers
P. O. Box 715
Orlando, Florida 32802

Florida Workers Compensation Managed Care Arrangement

THE WORKERS COMPENSATION MANAGED CARE ARRANGEMENT EMPLOYEE RIGHTS & RESPONSIBILITIES

Your Employer and workers compensation Carrier/Claim Administrator are committed to seeing that you receive appropriate medical treatment if you are injured on the job. Because you are a significant partner in your recovery, it is important that you understand your Workers Compensation Managed Care rights and responsibilities.

Employee Rights

- Prompt emergency treatment when needed (preferably through network facilities)
- Timely coordination of medical care ordered by authorized network physicians
- Return to Work as soon as medically feasible (possibly to modified duty, initially)
- Assistance in selection of Primary Care Physician
- Use of Grievance Policy (attached) to resolve disagreements about medical care
- Discussion of medical and Return to Work plans with the Medical Care Coordinator (MCC – gatekeeper) including:
 - ¾ Referral to a network physician or specialist
 - ¾ One time change in network physician during life of your claim
 - ¾ Possible second opinion with network provider
- Use of one Independent Medical Examination (IME), to gain another opinion about medical care
- Once during the life of the claim, a change in authorized physician, to another Network physician in the same specialty
- Medical treatment within reasonable distance from your usual work site (i.e., primary care within 30 miles and specialty care within 60 miles.)
- Medical care with a non-Network physician only if:
 - ¾ Physician is providing emergency care
 - ¾ Compensability of the claim has been denied
 - ¾ Physician provides medically necessary service that is not available through the Network and the service has been ordered by an authorized treating Network physician
- You should not receive billing from any authorized provider treating your work related injury. If you receive billing, contact your Claims Adjuster.
- For additional information about rights and responsibilities, contact the State of Florida's Workers' Compensation Employee Assistance Office using 800-342-1741

Employee Responsibilities

- Report your injury to your employer as promptly as possible
- If you are not clear about your rights and responsibilities, ask your employer and/or Travelers for assistance
- Participate in medical care with Network providers identified by or selected by your employer and/or Travelers.
- Participate in medical care as ordered by the authorized treating Network physician. If you are not working, participating in medical treatment is your job until you are able to Return to Work.
- For each medical appointment be sure to gain documentation of your Return to Work status and restrictions and give the document to your employer.
- Return to Work when released by your authorized treating Network physician and work within the restrictions (if any) identified by the physician.
- If you would like new or different medical care, discuss your request with the Medical Care Coordinator (MCC – gatekeeper) and/or treating Network physician
- If you have a complaint about your care, contact the Claims Adjuster or Medical Case Manager so that they can help resolve the problem.
- If the problem continues, by Florida law you must utilize the Grievance procedures to attempt to resolve the problem before filing a Petition for Benefits.

** Failure to cooperate with medical treatment may negatively affect (reduce or eliminate) your claim benefits.*

Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both.

If you have any questions, you may contact the WORKERS COMPENSATION MANAGED CARE ARRANGEMENT using: **1-800-842-6771** or your employer.

**EL CONVENIO DE CUIDADOS MÉDICOS ADMINISTRADOS DE COMPENSACIÓN LEGAL POR
ACCIDENTES DE TRABAJO
DERECHOS Y RESPONSABILIDADES DEL EMPLEADO**

Su empleador y el gestor de reclamaciones/compañía de seguros de compensación legal por accidentes de trabajo tienen el compromiso de verificar que usted reciba el tratamiento médico adecuado si sufre una lesión en el trabajo. Debido a que usted es una parte significativa en lo que respecta a su recuperación, es importante que entienda los derechos y las responsabilidades relacionados a los Cuidados Médicos Administrados de Compensación Legal por Accidentes de Trabajo.

Derechos del empleado

- Tratamiento de emergencia de inmediato cuando sea necesario (preferentemente a través de las instalaciones de la red).
- Coordinación oportuna de los cuidados médicos indicados por los médicos autorizados de la red.
- Reincorporación al trabajo tan pronto como sea posible, desde el punto de vista médico (posiblemente a tareas modificadas, en un comienzo).
- Ayuda para la selección de un Médico de Cabeza (PCP).
- Uso de la Política de Presentación de Quejas Formales (adjunta) para resolver desacuerdos en lo que respecta a los cuidados médicos.
- Conversación acerca de los planes médicos y de reincorporación al trabajo con el Coordinador de Cuidados Médicos (MCC – coordinador) incluyendo:
 - ¾ Referidos a un médico o especialista de la red
 - ¾ Cambio por única vez de médico de la red durante la vigencia de su reclamación
 - ¾ Segunda opinión posible a cargo de un médico de la red
- Uso de un Examen Médico Independiente (IME) para obtener otra opinión sobre los cuidados médicos.
- Por única vez durante la vigencia de la reclamación, un cambio de médico autorizado a otro médico de la red, de la misma especialidad.
- Tratamiento médico a una distancia razonable de su trabajo habitual (por ejemplo, servicios de atención primaria dentro de las 30 millas, y servicios de atención especializada dentro de las 60 millas).
- Cuidados médicos proporcionados por un médico que no pertenezca a la red, sólo si:
 - ¾ El médico proporciona cuidados de emergencia
 - ¾ Se ha denegado la compensación de la reclamación
 - ¾ El médico proporciona un servicio médico clínicamente necesario que no está disponible a través de la red y el servicio ha sido solicitado por un médico de la red a cargo del tratamiento
- Usted no recibirá facturas de ningún proveedor autorizado que esté a cargo del tratamiento de su lesión relacionada con el trabajo. Si recibe facturas, comuníquese con el Tasador de Reclamaciones.

Responsabilidades del empleado

- Para obtener información adicional sobre derechos y responsabilidades, comuníquese con la Oficina de Asistencia al Empleado de Compensación Legal por Accidentes de Trabajo del Estado de Florida llamando al 800-342-1741.
- Informe sobre su lesión a su empleador lo antes posible.
- Si no está seguro de sus derechos y responsabilidades, solicite ayuda a su empleador y/o a Travelers.
- Reciba cuidados médicos de proveedores de la red identificados o seleccionados por su empleador y/o Travelers.
- Reciba cuidados médicos según lo indicado por el médico autorizado de la red a cargo del tratamiento. Si no está trabajando, su tarea es participar en el tratamiento médico hasta que pueda volver a trabajar.
- En cada cita con el médico, asegúrese de obtener la documentación sobre su condición para la reincorporación al trabajo así como las restricciones, y entregue ese documento a su empleador.
- Reincorpórese al trabajo cuando el médico autorizado de la red a cargo de su tratamiento le autorice a hacerlo, dentro de las restricciones (si las hubiera) identificadas por el médico.
- Si desea recibir cuidados médicos nuevos o diferentes, hable sobre su solicitud con el Coordinador de Cuidados Médicos (MCC – coordinador) y/o con el médico de la red a cargo de su tratamiento.
- Si tiene una queja formal sobre los cuidados médicos recibidos, comuníquese con el Tasador de Reclamaciones o con el Gestor de Casos Médicos para que le ayuden a resolver el problema.
- Si el problema continúa, conforme a las leyes de Florida usted debe usar los Procedimientos de Presentación de Quejas Formales para intentar resolver el problema antes de presentar una Solicitud de Beneficios.

* *El hecho de no colaborar con el tratamiento médico puede afectar de manera negativa (reducir o eliminar) los beneficios correspondiente a su reclamación.*

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Cualquier persona o entidad que voluntaria y deliberadamente haga cualquier declaración o manifestación importante falsa con el fin de obtener algún beneficio o pago, o con el propósito de frustrar o, de manera indebida, incrementar o reducir cualquier reclamación para beneficio o pago de cobertura de la compensación legal por accidentes de trabajo, o que contribuya o incite a tal finalidad, podrá quedar sujeta a sanciones civiles o penales, o a ambas.

Si tiene alguna pregunta, puede comunicarse con el CONVENIO DE CUIDADOS MÉDICOS ADMINISTRADOS DE COMPENSACIÓN LEGAL POR ACCIDENTES DE TRABAJO llamando al: **1-800-842-6771** o a su empleador.

Florida Workers Compensation Managed Care Arrangement

GRIEVANCE POLICY

Your employer and the WC/MCA want to ensure that you receive appropriate medical treatment in the event you are injured on the job. If you would like treatment with a specialist or other medical services, you may contact your MCC or authorized treating physician to gain a referral. The grievance policy only applies to medical requests from authorized treating physicians in a specific claim.

1. Your first request for authorization of a physician or a medical service should always be made to the Case Manager or Adjuster who will strive to resolve your issue as promptly as possible. Your request may be referred to the MCC assigned to your claim, or an independent Physician Advisor. An opinion will be provided concerning the medical necessity and/or appropriateness of the request as related to your injury. You will receive a response to your concern within 7-14 days after we receive your request.
2. If at any time you are dissatisfied or have a complaint concerning the medical care and treatment provided for your work related injury, you should contact your Case Manager or Adjuster. Every effort will be made to resolve your complaint within 10 days of receipt. With your agreement, additional time may be utilized (if necessary) to resolve the problem.
3. If a specific request has been denied, within one year from the date of denial, you may file a formal written Grievance with the Grievance Coordinator of the WC/MCA. The Grievance Coordinator will review your case and make administrative decisions concerning your request. A decision will be provided within 14 days from the date we receive your written Grievance Form, and you will be promptly notified in writing of the results.

Specifically when you are requesting a second change in physician (after your statutory 1 time change in physician), you must attach medical documentation to the Grievance Form which substantiates that: you have not made significant progress in recovery after 6 months of treatment; treatment is not consistent with AHRQ guidelines; and/or treatment is not consistent with established codes of ethical medical conduct. The grievance process does not begin in this case without the necessary documentation attached to the Grievance Form.

Following review of your request by the Grievance Coordinator, if the request continues to be denied, you will be informed that your request will be forwarded to the Grievance Committee for review. The committee, including a Florida licensed physician, will review the request within 30 days of the committee's receipt of the grievance. Occasionally, an additional 14 days is needed because additional information is required. You will be promptly informed in writing, of the Grievance Committee status and decision.

4. You may file an "Urgent Grievance" if your PCP or MCC determines that your medical status is at significant risk of deterioration if a response is not made within 72 hours. The Grievance Coordinator will review the request and notify you of the decision within 3 days.

For both the formal Grievance and the Urgent Grievance requests, completion of AHCA form No. 3160-0019 is required. According to Florida Workers Compensation law, a Petition for Benefits is not a Grievance, and the Petition for Benefits form may not be used to replace the Grievance Form. The Grievance Form is attached, or you may use the contact information below to request the form.

According to Florida law, you may file a Petition for Benefits only upon completion of the grievance process above. The Workers Compensation Employee Assistance Office can be contacted at 200 East Gaines St., Tallahassee, FL 32399-4225. You may also contact the Employee Assistance Office using 800-342-1741.

Every effort will be made to resolve your grievance at the earliest possible time. Most verbal requests or complaints can be resolved at the time of the initial telephone conversation. At any time during the processing of your grievance, you may request a personal meeting to be held at a convenient location.

If you have any questions concerning the WC MCA Grievance Process, please call 1-800-448-0798 or write:

Travelers
Workers Compensation Managed Care Arrangement
ATTN: GRIEVANCE COORDINATOR
P. O. Box 715
Orlando, FL 32802

POLÍTICA DE PRESENTACIÓN DE QUEJAS FORMALES

Su empleador y WC MCA quieren asegurarse de que usted reciba el tratamiento médico adecuado en caso de que sufra una lesión en su trabajo. Si desea recibir tratamiento por parte de un especialista u otros servicios médicos, puede comunicarse con su MCC o con el médico autorizado a cargo de su tratamiento para que le otorguen un referido. La política de presentación de Quejas Formales sólo se aplica a solicitudes médicas de médicos autorizados a cargo del tratamiento en una reclamación específica.

1. Su primera solicitud de autorización de médico o servicio médico debe presentarse siempre al Gestor de Casos o al Tasador quienes se esforzarán por resolver su problema lo antes posible. Su solicitud puede ser referida al MCC asignado a su reclamación, o a un Asesor Médico Independiente. Se dará una opinión en lo que respecta a la necesidad médica y/o a la idoneidad de la solicitud en relación con su lesión. Recibirá una respuesta a su inquietud entre los 7 y los 14 días posteriores a la recepción por parte nuestra de la solicitud.
2. Si en algún momento no se siente satisfecho o tiene una queja relacionada con el tratamiento y los cuidados médicos proporcionados para su lesión relacionada con el trabajo, comuníquese con su Tasador o Gestor de Casos. Haremos todos los esfuerzos posibles para encontrar una solución a su queja dentro de los 10 días posteriores a la recepción de la misma. Con su consentimiento, podemos hacer uso de tiempo adicional para resolver el problema (de ser necesario).
3. Si se ha denegado una solicitud específica, dentro de un plazo de un año contado a partir de la fecha de la denegación, usted puede presentar una queja formal por escrito al Coordinador de Quejas Formales del WC MCA. El Coordinador de Quejas Formales revisará su caso y tomará las decisiones administrativas relacionadas con su solicitud. Se tomará una decisión dentro de los 14 días posteriores a la recepción por parte nuestra de su Formulario de Presentación de Queja Formal, y le proporcionaremos a la brevedad una notificación por escrito de los resultados.

Específicamente cuando usted nos solicite un segundo cambio de médico (después de solicitar el reglamentario cambio de médico por única vez), debe adjuntar la documentación médica al Formulario de Presentación de Queja Formal que pruebe que: no se han logrado avances de importancia en la recuperación después de 6 meses de tratamiento; el tratamiento no concuerda con las directrices de la Agencia de Investigación y Calidad de la Atención Médica (AHRQ, por sus siglas en inglés); y/o el tratamiento no concuerda con los códigos de ética médica establecidos. No se da inicio en este caso al proceso de presentación de quejas formales si no se adjunta la documentación necesaria al Formulario de Presentación de Queja Formal.

Después de que el Coordinador de Quejas Formales revise su solicitud, si se sigue denegando la solicitud, se le informará que su solicitud será enviada al Comité de Quejas Formales para su revisión. El comité, que incluye un médico con licencia de Florida, revisará la solicitud dentro de los 30 días posteriores a la fecha en que el comité reciba la queja formal. De vez en cuando, se necesitan 14 días más porque es necesario obtener más información. Se le informará por escrito a la brevedad acerca del estado y la decisión del Comité de Quejas Formales.

4. Puede presentar una "Queja Formal Urgente" si su PCP o MCC determina que su condición médica muestra un riesgo significativo de deterioro si no se obtiene una respuesta dentro de un plazo de 72 horas. El Coordinador de Quejas Formales revisará la solicitud y le notificará sobre la decisión en un plazo de 3 días.

Tanto para las solicitudes de Queja Formal y Queja Formal Urgente, se requiere completar el formulario No. 3160-0019 de la Agencia para la Administración del Cuidado de la Salud (AHCA). Conforme a la ley de Compensación Legal por Accidentes de Trabajo de Florida, una de Solicitud de Beneficios no es una Queja Formal, y el formulario de Solicitud de Beneficios no puede ser utilizado para reemplazar un Formulario de Presentación de Queja Formal. Se adjunta el Formulario de Presentación de Queja Formal, o bien, usted puede usar la información que aparece más abajo para solicitar el formulario.

Conforme a las leyes de Florida, usted puede presentar una Solicitud de Beneficios sólo después de completar el proceso de presentación de queja formal que se indica más arriba. Puede comunicarse con la Oficina de Asistencia al Empleado de Compensación Legal por Accidentes de Trabajo [Workers Compensation Employee Assistance Office] que se encuentra en 200 East Gaines St., Tallahassee, FL 32399-4225. También puede comunicarse con la Oficina de Asistencia al Empleado llamando al 800-342-1741.

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Se harán todos los esfuerzos posibles para resolver su queja formal lo antes posible. La mayoría de las solicitudes o quejas formales pueden ser resueltas en la conversación telefónica inicial. En cualquier momento, mientras se procesa su queja formal, puede solicitar una reunión personal a ser realizada en una ubicación que le resulte conveniente.

Si tiene alguna pregunta sobre el Proceso de Presentación de Quejas Formales de WC MCA, llame al 1-800-448-0798 o escriba a:

Travelers Workers Compensation Managed Care Arrangement
Attn: GRIEVANCE COORDINATOR,
P. O. Box 715, Orlando, FL 32802

Florida Workers Compensation Managed Care Arrangement

See Reverse of Form for Information Regarding Filing a Grievance
Florida Workers' Compensation Managed Care Arrangement

FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

The Grievance is being filed by: Provider Injured Worker / Designated Representative Family Member
 Attorney Other

Date of Injury: _____

INJURED WORKER'S /PROVIDER'S NAME: _____

Social Security Number _____

Address: _____

Home Telephone: _____ Work / Alternate Phone: _____

Contact if other than injured worker or provider _____ Telephone # _____

PRIMARY CARE / TREATING PHYSICIAN: _____

Address: _____

Office Telephone: _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem):

Has a grievance been previously filed? YES NO. If YES, Date Sent? _____

What Action Would You Like to See Taken? _____

Have you received any information regarding your rights and responsibilities under WC Managed Care?
YES NO

Form 3160-0019 November, 2000

Florida Workers Compensation Managed Care Arrangement

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt, unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: _____
Injured Worker/Provider/Other

Date Form Completed/Signed

Signature of Grievance Coordinator

Date Grievance Coordinator Signed

MAIL TO:

The Workers Compensation Managed Care Arrangement
Travelers
ATTN: GRIEVANCE COORDINATOR
P.O. Box 715
Orlando, FL 32802

Florida Workers Compensation Managed Care Arrangement

FLORIDA WORKERS COMPENSATION MANAGED CARE

Acknowledgement Form:

I acknowledge receipt, review and understanding of the Florida Workers Compensation Managed Care educational materials.

Date

Name

Signature

Florida Workers Compensation Managed Care Arrangement

ATENCIÓN ADMINISTRADA DE LA FLORIDA

Formulario de Acuse de Recibo:

Reconozco que he recibido, revisado y entendido los materiales informativos de Atención Administrada de Compensación Legal por Accidentes de Trabajo de la Florida.

Fecha

Nombre

Firma

FLORIDA POLICYHOLDERS AVAILABILITY OF RISK MANAGEMENT PLANS

Florida insurance statute require insurers to provide insureds, at their request, with guidelines for risk management plans. Travelers Risk Control department has available guidelines to assist you with your accident prevention activities.

The companion Safety Services notice describes the range of services available to our insureds. Should you desire assistance with regard to your accident prevention activities, please contact us at the Florida location specified in the notice.

FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

- Resource file on providers
 - Employee Assistance Program
 - Education

Name of Medical Review Officer: _____

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

B. Phone #: () _____

C. Address: _____

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

Employer Name

Date

Officer/Owner Signature *

Title

* Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature

Date

Expiration of Commission

(NC3010)
Form 09-1

W09NDG04

FLORIDA SAFETY SERVICES

Notice to policy recipient: If you are not the person directly responsible for the loss control activities for your company, please direct this Loss Control notice to the person that is directly responsible for them

SAFETY IS OUR CONCERN

Thank you for purchasing your insurance from one of the writing companies owned or managed by The Travelers Companies, Inc. We appreciate your business and welcome the opportunity to be of service.

An important part of that service concerns safety and accident prevention. Travelers Risk Control department has the experience, resources and capabilities to provide a range of safety services, including site surveys, phone consultations, and a wealth of safety-related materials.

We have experience in a variety of industries, some of which include manufacturing, wholesale and retail businesses, service organizations, technology-related business, oil and gas-based business, and the public sector.

Following are some examples of available loss control services:

Accident Prevention – Our staff can help you identify present and potential hazards in your operations, premises and equipment, and recommend measures for reducing or eliminating these hazards.

Analysis of Accident Causes – Although you investigate and keep records of accidents, we are available to assist if needed.

Safety Consultations – Our Consultants can help you with special problems such as ergonomics and human factors.

These services are available upon request. Please call us at 407-388-3307 for loss control assistance. Please do not call this number for questions regarding your policy or claims. For all other inquiries, please contact your underwriter or agent.

Industrial Hygiene/Health Services – We have the facilities and resources to answer your questions concerning job related industrial hygiene/health issues and to measure exposure to industrial hygiene hazards.

Safety Literature and Digital Media – We can provide you with top-notch safety-related literature, CDs, DVDs, and videos to assist in your loss control efforts. Also, we can direct you to several vendors who are able to provide additional safety materials, including brochures, pamphlets and digital media.

Safety Training – We offer face-to-face classroom courses, as well as distance learning programs that explore the risks our policyholders face and ways for them to control losses.

Return-To-Work Coordination – We can assist you with several aspects of the post injury management process.

Internet Website – Visit our Risk Control website for access to our safety newsletters and other safety literature at:

<http://www.travelers.com/riskcontrol>

This website also has links to other safety-related Internet sites.

SAFETY IS YOUR CONCERN

U.S. employers spend billions of dollars each year on the direct and indirect costs of work-related accidents. Dollar figures can't begin to reflect the pain and suffering of an injured worker and his or her family. But they do give some indication of the multiple consequences of a job-related accident... loss of time, interrupted production, damaged materials and equipment, the expense of retraining or replacing an injured worker, possible legal action from government regulatory agencies, and increased insurance costs.

It makes good sense for both employers and their employees to actively participate in a sound accident prevention program. The success of such a program depends to a large extent on your commitment to safety procedures and accident prevention techniques. Safety is a management concern. Maybe we can help.

You may want to consider the following "**Safety Checkpoints**" as you evaluate your organization's safety activities:

SELF-INSPECTION PROGRAM:

- Do you conduct periodic surveys of premises?... equipment?... operations?

SELF-INSPECTION PROGRAM (continued):

- Do you analyze each job to find inherent hazards?
- If you discover hazards, do you follow up with immediate corrective action?
- Do you monitor such action to make sure it is implemented and effective?

ACCIDENT INVESTIGATION:

- Do you investigate each accident?... determine the cause?
- Do you take immediate steps to prevent a recurrence?
- Do you keep records of accident investigations and follow-up measures?
- Do you complete accident statistics and analyze trends?

EDUCATION AND TRAINING:

- Do you take the time to train each of your employees to perform tasks safely?
- Do more-experienced employees receive training to correct bad habits that have developed over time?
- Do all employees understand that safety is an important part of their jobs?

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Physical therapy
- Hospitalization
- Medical tests
- Prostheses
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a \$10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- **Temporary Total Benefits:** These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- **Temporary Partial Benefits:** These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. **Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.**
- **Permanent Impairment Benefits:** These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned.
(Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at http://www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/WC/employee/index.html, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/WC/faq/faqwrkrs.html.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is free and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Re-employment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at www.rehabworks.org or call 850-245-3470 for free re-employment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

Disclaimer:

This publication is being offered as an informational tool only and complies with s.440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

Si usted se lesiona como resultado de un accidente de trabajo, la compañía de seguro de su empleador podría proveerle beneficios médicos y una porción de su salario.

Beneficios Médicos

Tan pronto la compañía de seguro tenga conocimiento de su lesión y determine que su lesión/enfermedad tiene cobertura de acuerdo a las leyes de la Florida, la compañía de seguro le:

- Proveerá un médico autorizado por la compañía de seguro
- Pagará por todo tratamiento que sea autorizado, médicaamente necesario y relacionado a su lesión o enfermedad
- Proveerá una vez un cambio de medico dentro decinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de viajes a consultas médicas o la farmacia

En cuanto alcance la máxima mejoría médica (MMI por su sigla en inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo(a) atiende determina que su lesión o enfermedad ha sanado hasta el punto que una mejoría adicional no es probable.

Beneficios de Reemplazo de Salario

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su empleo, es posible que usted pueda recibir reemplazo parcial del salario. Usted puede ser elegible para estos beneficios si ha estado incapacitado(a) por mas de siete días y no ha podido cumplir con sus deberes normales en su empleo según el consejo de su médico autorizado.

Si usted califica, los beneficios de reemplazo de salario comenzarán al octavo día de incapacidad parcial o total. Usted no recibirá beneficio de reemplazo de salario por los primeros siete días de incapacidad a menos que usted ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionado con su empleo.

En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular que usted ganaba antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Usted generalmente, puede esperar recibir su primer cheque de beneficio dentro de 21 días después de que la compañía de seguro tenga conocimiento de su lesión o enfermedad. Los (siguientes) cheques (adicionales) se enviarán quincenalmente.

- Beneficios Por Incapacidad Total Temporal (TTD por su sigla en inglés)* :Estos beneficios son proveídos como resultado de una lesión u enfermedad que temporalmente prohíbe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.

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- Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)* :Estos beneficios son proveídos cuando el médico le permite volver a trabajar, usted no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad.* **Beneficios temporales son pagables por un máximo de 104 semanas o hasta la fecha que se determine que usted ha alcanzado la máxima mejoría médica, lo que ocurra primero.**
- Beneficios por Daños Permanente (IB por su sigla en inglés):Estos beneficios son proveídos cuando la lesión o enfermedad causa pérdida física, psicológica o funcional y la incapacidad existe después de la fecha de la máxima mejoría médica. [MMI] Un médico le asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje de incapacidad al cuerpo en su totalidad.
- Beneficios por Incapacidad Total Permanente (PTD por su sigla en inglés): Estos beneficios son proveídos cuando la lesión causa que usted sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por Fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

La tasa, cantidad, y duración de beneficios de reemplazo de salario son estipulados en la ley de compensación por accidentes de trabajo. **Si usted tiene preguntas sobre sus beneficios llame a su tasador(a) /ajustador(a) de reclamo o a la Oficina de Ayuda al Trabajador al 1-800-342-1741 Ext. 30027.**

Responsabilidades del Trabajador Lesionado

Comuníquese con el Empleador:

- Contacte su supervisor/empleador inmediatamente para notificarle que sufrió una lesión o enfermedad en su trabajo.
- Provéela a su empleador una copia del Formulario Para Reportar el Estatus de su Caso y Tratamiento Médico (formulario médico para reportar el tratamiento/estado de su caso) (DWC25) [titulada en Ingles "Medical Treatment/Status Reporting Form (DWC25)"] después de cada cita médica.
- Vuelva a su lugar de empleo cuando su médico lo permita y su empleador le ofrezca un trabajo de acuerdo a sus limitaciones para evitar la suspensión de los beneficios de reemplazo de salario.

Comuníquese con la compañía de seguros:

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés "First Report of Injury or Illness" (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no esta de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíquese a su tasador(a)/ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, esta confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provée la declaración a la compañía de seguros.

INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJODORES DE LA FLORIDA

- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted está representado por un abogado, posiblemente su tasador(a) /ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

Comuníquese con el Médico Autorizado por la Compañía de Seguros:

- Identifique todas las partes del cuerpo que están o potencialmente pueden ser dañadas, y sea específico(a) al identificar las áreas del dolor.
- Cumpla con sus citas médicas.
- Aclare su estado laboral durante sus citas antes de salir de la oficina del médico.
- Siga el plan recomendado por su médico.
- Pídale a su médico una copia del Reporte Médico Sobre el Estado/Tratamiento de su Caso (DWC25) [titulada en inglés, "Medical Treatment /Status Reporting Form (DWC25)"].
- Notifique a su médico de cualquier cambio de dirección o número de teléfono.
- Llame a la oficina del médico autorizado si usted necesita ver al médico antes de su próxima cita. Quizás el personal pueda anotar su nombre en una lista de cancelación y pueda conseguir una cita más pronto si otro paciente cancela su cita. Si no hay una cita disponible, y usted necesita ver un médico inmediatamente, por favor contacte su tasador(a)/ajustador(a) de reclamo o la Oficina de Ayuda al Trabajador.

Responsabilidades de la Compañía de Seguros

- Disposición oportuna del tratamiento médico
- Pago oportuno de beneficios de reemplazo de salario
- Pago oportuno de facturas médicas
- Notificación oportuna de su reclamo a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamo. Esta información le será proveída por correo en una hoja titulada Notificación de Acción o Cambio (DWC4) [Titulado en inglés "Notice of Action/Change (DWC4)"] o en una Notificación de Negación (DWC12) [Titulado en inglés Notice of Denial (DWC12)].

Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assistance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO **1-800-342-1741 Ext. 30027**. Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir

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o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar. Usted puede localizar estas oficinas estatales visitando nuestra página de web: http://www.fldfs.com/WC/organization/eao_offices.html

Servicios Proveído por el EAO incluyen:

- Educar y proveer información sobre su reclamo.
- Asistirle a resolver desacuerdos referentes a su reclamo sin ningún costo para usted.
- Asistirle a entender los procedimientos para iniciar el proceso judicial y someter una petición de beneficios a la oficina de jueces de reclamaciones de compensación.

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados

Lesionados " en la página Web de la División de Compensación por Accidentes de Trabajo: www.MyFloridaCFO.com/WC/employee/index.html

Se pueden obtener las respuestas a preguntas que se hacen con frecuencia en: www.MyFloridaCFO.com/WC/faq/faqwrkrs.html. Usted también puede someternos sus preguntas específicas relacionadas con su reclamo al wceao@MyFloridaCFO.com y recibir la respuesta directamente por correo electrónico.

Estatuto de Limitaciones

Una vez que usted se ha dañado en su trabajo o se da cuenta que su lesión es relacionada a su trabajo, usted tiene 30 días para reportar su lesión a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su demanda.

Generalmente, usted tiene dos años a partir de la fecha de su lesión o enfermedad para reclamar beneficios por accidentes de trabajo. La falta de reportar su lesión u enfermedad en el plazo de 30 días se puede utilizar como defensa contra su reclamo sin importar el estatuto de dos años de las limitaciones para archivar una reclamación. Su elegibilidad para beneficios de reemplazo de salario se puede terminar un año después de recibir el último cheque de beneficio de reemplazo de salario o del último tratamiento médico que fue autorizado.

Negación de Beneficios

Si la compañía de seguro no le provee los beneficios que usted cree que tiene derecho a recibir, puede contactar a la Oficina de Ayuda al Trabajador (EAO). Aunque la EAO no provee consejos legales, nuestros especialistas contestarán preguntas sobre sus derechos y responsabilidades y posiblemente resuelvan problemas que usted tenga con su reclamo. Esta ayuda es **gratis** y disponible si contacta EAO al **1-800-342-1741 Ext. 30027**.

Petición por Beneficios

Para comenzar el procedimiento judicial para obtener beneficios que se le deben según la ley y no han sido proveídos por el empleador o la compañía de seguros, debe presentar el formulario Petición por Beneficios (titulado en inglés Petition for Benefits) a la Oficina de Jueces de Reclamos de Compensación. El formulario se puede obtener en el sitio: www.jcc.state.fl.us/jcc/forms/.asp.

Servicios de Reempleo

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo anterior, puede contactar al Departamento de Educación, División de Rehabilitación Vocacional en www.rehabworks.org o puede llamar al 850-245-3470 para recibir servicios de re-empleo gratis.

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Representación Legal

No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la División de Compensación por Accidentes de Trabajo no provee asesoramiento legal, la División contestará preguntas sobre sus derechos y responsabilidades y posiblemente podrá resolver problemas que usted pueda tener con su reclamo. La ayuda es **gratis** y está disponible si usted contacta la Oficina de Ayuda al Trabajador (EAO) al **1-800-342-1741 Ext. 30027**.

Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosa. El fraude de seguros por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta \$25,000.00 se pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al 1-800-378-0445 para reportar sospechas de fraude de seguro por accidentes de trabajo.

Limitación de responsabilidad

Esta publicación está siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ninguna circunstancia será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.

IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA

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

Please review your policy carefully. Should you have any questions concerning coverages, billings, additions or deletion, please contact your agent. Should you feel the need for additional information or wish to make a complaint, we offer the following number:

For information or to make a complaint, call
1-800-328-2189

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: **(TRJUB-4246B09-2-14)** Effective Date of Policy: **04-01-14**

I am submitting a copy of my workplace safety program that meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

- | | |
|---|-----------------------------|
| 1) Written safety policy and safety rules | 5) First aid |
| 2) Safety inspections | 6) Accident investigation |
| 3) Preventative maintenance | 7) Necessary record keeping |
| 4) Safety training | |

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any misleading or untrue information. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that if I knowingly and willfully falsify or conceal a material fact, make a false, fictitious or fraudulent statement or representation; or make or use any false document knowing the document to contain any false, fictitious or fraudulent entry or statement to my carrier of workers compensation insurance under Section 442, Florida Statutes, I will be guilty of a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes, and will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence; and

I am also aware that if I, in any matter within the jurisdiction of the division, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent entry, that I commit a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes. Moreover, I understand that an employer who commits such an act will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

State of Florida

County of _____

Sworn to, or affirmed, and subscribed before me

this _____ day of _____

20 _____, by _____

(Signature)

(Print Name and Title)

(Date)

(Signature of Notary)

(Expiration Date and Number)

IMPORTANT NOTICE – COMPLAINTS – ILLINOIS

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

If you are having problems you may contact your insurance agent directly or you may contact the company at:

Mail: Consumer Affairs
One Tower Square
Hartford, CT 06183

Phone: (860) 277-1561 or

Email: consumeraffairs@travelers.com

The address of the consumer complaint division of the Illinois Department of Insurance is:

Illinois Department of Insurance
Consumer Division
320 W Washington St
Springfield, IL 62767

Complaints may also be filed electronically to the Illinois Department of Insurance at
<https://insurance.illinois.gov/applications/ComplaintForms/default.aspx>



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **(TRJUB-4246B09-2-14)**

IMPORTANT NOTICE

RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT – ILLINOIS

The Illinois Religious Freedom Protection and Civil Union Act provides that persons of the same or opposite sex who enter into a civil union must be afforded the same obligations, protections, and legal rights as married persons. This law became effective June 1, 2011, and is designed to ensure that civil unions and marriage are treated identically under Illinois law. In accordance with law, this policy will be interpreted to provide the same benefits and protections to persons in a civil union or in a marriage.

ATTENTION

IMPORTANT INFORMATION FOR INJURED EMPLOYEES

CLAIMS ADVISORY/OMBUDSMAN

DIVISION OF WORKERS COMPENSATION
800 SW JACKSON STREET STE 600
TOPEKA KS 66612-1227

TOLL FREE 1-800-332-0353

If you were hurt on the job and have any questions about Workers Compensation benefits contact the **Claims Advisory Section** at the Kansas Division of Workers Compensation. The Division of Workers Compensation has full-time personnel who specialize in aiding injured workers with claim information and problems. They can give information about benefits an injured worker is entitled to receive. They can help try to solve problems with benefits not being paid on time, with medical treatment, with unpaid medical bills, with questions about how to figure settlement amounts, etc. Spanish interpreters are available at the Division of Workers Compensation.

WHAT TO DO IF AN ACCIDENT OCCURS ON THE JOB:

1. Tell your employer that you were hurt on the job.
2. Follow your employer's instructions on getting medical aid and follow the doctor's instructions.
3. Within 200 days of the date of accident or the date of last payment of compensation for disability or authorized medical care, tell your employer **in writing** that you expect workers compensation benefits for your injury. Your employer might know you were hurt and compensation may be paid, however, you could lose all rights to future compensation if you do not tell the employer **in writing**. This is called a "**Written Claim**." Written claim may be served in person by taking it to the employer and getting a receipt for it or by mailing it to the employer by certified mail, return receipt requested. The post office receipt for the certified letter is generally sufficient proof that you sent written claim.

AVERAGE WEEKLY WAGE: A worker's "average weekly wage" is calculated by adding together the **base wage**, the **average weekly overtime** and the **weekly value of fringe benefits** that have been discontinued.

WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are

off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of \$500. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more.

RESPONSIBILITIES OF THE EMPLOYER:

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury.
2. Employers must provide for the payment of workers compensation claims without any charge to employees.
3. Employers must post written notice of workers compensation insurance coverage in both Spanish and English.
4. Employers must pay compensation benefits regardless of insurance coverage.
5. Upon receiving notice of an injury, employers must provide the employee with written information to assist the injured worker in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS:

YOUR CLAIM WILL BE HANDLED BY:

Company _____

Address _____

Contact Person _____

Telephone (____) _____



Information for Kansas Employers and Employees



Copies of election forms, accident reports, the Posting Notice (K-WC 40 and K-WC 40-A) and all other mandated posters are available to download at www.dol.ks.gov.

For additional information on workers compensation benefits, employer guidelines and other general information, contact:

Kansas Department of Labor
Division of Workers Compensation
401 SW Topeka Blvd.
Topeka, Kansas 66603
(785) 296-4000
(800) 332-0353
Email: wc@dol.ks.gov
Website: www.dol.ks.gov

For more information on workers compensation insurance rates and insurance carrier conduct, contact:

Kansas Department of Insurance
420 S.W. 9th Street Topeka,
Kansas 66612-1678
(785) 296-3071
(800) 432-2484
Email: commissioner@ksinsurance.org
Website: www.ksinsurance.org

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What is Workers Compensation?

Workers compensation is a required insurance plan provided by the employer to pay employee benefits for job-related injuries, disability or death that arise out of and in the course of employment.

Per K.S.A. 44-508, an injury by accident shall be deemed to arise out of employment if:

- There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
- The accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment.

The words "arising out of and in the course of employment" as used in the Workers Compensation Act shall not be construed to include:

- Injury which occurred as a result of the natural aging process or by the normal activities of day- to-day living;
- accident or injury which arose out of a neutral risk with no particular employment or personal character;
- accident or injury which arose out of a risk personal to the worker; or
- accident or injury which arose either directly or indirectly from idiopathic causes.

Benefits are paid at the employer's expense. Coverage begins the first day on the job.

The present law covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of \$20,000 or less. All payroll is taken into account, including that paid in Kansas or elsewhere. If the employer is a sole proprietor or a partnership, the wages paid to the owners and any of their family members are not used in the computation of the gross annual payroll.

Employees who are disabled due to a job-related injury or disease are entitled to:

- medical expenses to treat the job-related injury or illness; and
- income benefits to replace part of the wages lost due to disability.

If death results from a job-related injury or disease, benefits may be paid to the surviving spouse, dependents or heirs.

Purpose of the Law

Kansas passed its first workers compensation law in 1911. By regulating litigation and benefits, the law is designed to protect the interests of both employers and employees. Employers benefit by substituting a known expense (premiums) for the risk of large, unbudgeted expenses in the event of serious employee disabilities. Employees benefit because negligence of the employer is not an issue in determining liability. Workers compensation coverage is a no-fault system. The provisions of the Workers Compensation Act shall be applied impartially to both employers and employees. While initially aimed at hazardous jobs, the law now covers most workers.

Elections

Elections in or out of the Workers Compensation Act are options available to employers or employees. Depending on the circumstances, options may be available for:

- non-covered employers – e.g., those with payrolls of \$20,000 or less or in certain agricultural pursuits;
- corporate employees owning 10 percent or more of stock;
- individuals, proprietors or partnerships;
- employers seeking coverage for volunteers and other non-covered workers; and
- volunteer directors, officers or trustees of a nonprofit organization.

Example: A two-person partnership has two employees – a family member and a non-family member – and an annual payroll of \$15,000. The partnership may elect to purchase coverage under the Act and to extend such coverage to both employees. The partners are not covered because they are considered to be the employer.

Election forms can be found on online at www.dol.ks.gov.

Employee Rights and Responsibilities

Kansas law protects an employee's right and ease in obtaining workers compensation. Specifically:

- An employee cannot be fired, demoted or otherwise discriminated against for filing a claim in good faith.
- Employees must be informed of their rights and responsibilities in case of injury. In the event of employee death, such information must be furnished to the employee's beneficiaries.
- Employees must not be charged for the payment of workers compensation claims. Employers cannot deduct from pay or benefits to pay insurance premiums or claims.
- Employees may be entitled to compensation benefits from an employer subject to the Act regardless of insurance coverage.
- Employees may obtain free assistance by contacting the Workers Compensation Ombudsman's office at (800) 332-0353 or (785) 296-4000.
- The law provides specific penalties for employee or employer fraud in workers compensation cases. For assistance or more information, or to report suspected fraud, contact the Workers Compensation Ombudsman or the Fraud and Abuse office at (800) 332-0353 or (785) 296-4000.

Employer Responsibilities

Workers Compensation Insurance

Most employers are required by law to provide for the payment of workers compensation claims, at no expense to the employee. Employers shall satisfy this requirement in one of three ways:

- **Workers compensation insurance:** obtained from a licensed insurance carrier; the employer pays the premiums and the insurance company pays the claims. The insurance carriers are regulated by the Kansas Insurance Department.
- **Self-insurance:** an individual employer must demonstrate to the State the financial ability to pay any claims that might arise. This program is administered by the Division of Workers Compensation.
- **Group-funded pool:** a group of employers meeting certain statutory requirements may form a self-insurance program to jointly insure their ability to pay claims. This program is administered by the Kansas Department of Insurance.

Intentional failure to provide for workers compensation payment in one of the above ways is a **class A misdemeanor** and subjects the employer to a civil penalty in an amount twice the annual premium the employer would have paid for insurance or \$25,000, whichever amount is greater.

Employment categories excluded from the law are:

- certain agricultural pursuits;
- realtors who qualify as independent contractors;
- employers with gross annual payrolls of \$20,000 or less;
- firefighters belonging to a firefighters relief association which has waived coverage under the workers compensation law; and
- certain owner-operator vehicle drivers covered by their own occupational accident insurance policy.

OTHER REQUIREMENTS

- Employers must post written notice ([K-WC 40](#) and [K-WC 40-A](#)) advising employees what to do in case of injury.
- Employers must file, or cause to be filed, an accident report with the Division of Workers Compensation within 28 days from the date of reportable injury, death or employer notification of such. Failure to do so may result in legal and financial penalties.

- Immediately upon learning of an employee's injury or death, the employer must furnish written information to the employee or employee's dependents on available benefits, the claims process, an employer or insurance company contact for workers compensation claims, and other matters as required by law. Forms K-WC 27 / 27-A, and K-WC 270 / 270-A (Spanish) are available from the Division of Workers Compensation website at www.dol.ks.gov.
- An insurer or self-insured employer shall provide the following notice to an insured worker on or with the first check for temporary disability benefits: *Warning: Acceptance of employment with a different employer that requires the performance of activities you have stated you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in loss of future benefits and restitution of prior workers compensation awards and benefits paid.*

If you need assistance, call (800) 332-0353 or (785) 296-4000.

Categories of Disability Benefits

Temporary Total Disability

Exists when the employee, on account of injury, is unable to engage in any type of substantial and gainful employment. Benefits are paid for the duration of the temporary total disability (TTD). There is a one-week waiting period (seven calendar days) before TTD benefits are paid. If the disability continues for three consecutive weeks, the employee is reimbursed for the waiting period. Employees

may collect medical benefits during the first week. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than \$25 nor more than the statutory maximum. Temporary total compensation may not exceed \$130,000 per injury.

Employees may **not** collect temporary total disability and unemployment benefits for the same weeks.

Temporary Partial Disability

Exists when the worker returns to any employment at a wage less than the time of injury wage. Compensation is calculated on a weekly basis and is paid until the wage loss is no longer present or the benefit maximum is reached, whichever comes first.

Benefits are 66.67 percent of the difference between the employee's average gross weekly wage before the injury and the employee's wage after the injury. Benefits may not exceed the state's statutory maximum.

Permanent Partial Scheduled Disability

Exists when there is complete or partial loss of or loss of use of a body part, such as an arm, due to a job-related injury. Compensation for permanent partial scheduled disability is limited to a percentage of the following schedule. A healing period is available in cases of amputation. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than \$25 nor more than the statutory maximum cap of \$130,000.

Benefit Information Schedule

Loss of or loss of use of:	Weeks Paid:	Loss of or loss of use of:	Weeks Paid:
Shoulder	225	Thumb	60
Arm	210	1st (index) finger	37
Forearm	200	2nd (middle) finger	30
Hand	150	3rd (ring) finger	30
Leg	200	4th (little) finger	15
Lower leg	190	Great toe	30
Foot	125	Great toe, end joint	15
Eye	120	Each other toe	10
Hearing, both ears	110	Each other toe, end joint only	5
Hearing, one ear	30		

Permanent Partial General Disability

Exists when a worker is disabled in a manner which is partial in character and permanent in quality, and which is not covered by the schedule above. For example, disability involving the back or the loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity; or the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or foot of the other lower extremity; or the loss of or loss of use of both eyes which is partial in character and permanent in quality are whole body disabilities and are not covered by the above schedule. Compensation for such "non-scheduled" or "whole body" disability is based on the greater of the following: the percentage of functional impairment; or, the employee's reduced ability to perform work tasks and the average weekly wage the employee is capable of earning after the injury. Employees earning 90 percent of pre-injury wage are limited to functional impairment.

Calculating Permanent Partial General Disability Benefits

- Calculate weekly benefit rate by identifying the smaller of these two amounts:** Gross average weekly wage x 66.67 percent; or the statutory maximum.
- Calculate allowable weeks of compensation:** Begin with 415 weeks. Subtract from 415 the number of weeks of temporary total disability paid, excluding the first 15 weeks of such temporary total paid. Multiply the difference by the percentage of disability.
- Calculate total benefits:** Multiply weekly benefit rate by allowable weeks of compensation.

Example: Average weekly wage is \$875 at date of accident (7/10/2011). Employee has collected 25 weeks of temporary total disability and has a 25 percent disability rating.

Weekly benefit rate: (use lesser amount)

$\$875 \times .6667 = \583.36

statutory maximum (as of 7/1/11) \$555

Allowable weeks of compensation:

$415 - [25-15] = 415 - 10 = 405 \text{ weeks}$

$405 \text{ weeks} \times .25 = 101.25 \text{ weeks}$

Maximum benefit amount:

$101.25 \text{ weeks} \times \$555 = \$56,193.75$

Our website has a Workers Compensation [Calculation Program](#). The date program allows you to calculate time between two dates or to calculate the addition of days to a known date. The scheduled injury and whole body injury programs will allow you to compute the compensation benefits due to the claimant. Step-by-step instructions are provided for each program.

Permanent Total Disability

Exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, both legs or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall also constitute permanent total disability.

Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than \$25 nor more than the statutory maximum. Total compensation may not exceed \$155,000 per injury.

An employee is not allowed to receive more than one award of permanent total disability in a lifetime.

How Rates are Determined

Workers compensation insurance in Kansas is mandated by state law for most but not all employers. The premiums paid by the employers should be sufficient to cover the claims incurred by their insurance companies. Rates are adjusted based on the most recent premiums, investment income and losses reported by the insurance companies. The National Council on Compensation Insurance (NCCI) submits these rates annually to the insurance commissioner for approval.

The NCCI is a ratemaking organization, licensed by the Insurance Department, whose membership is primarily comprised of insurance companies. They develop the annual rate change needed based on the losses and premium reported to them by their member insurance companies.

The Kansas Insurance Department regulates the rates charged in Kansas. Each year, the Insurance Department reviews premiums, claims costs and other relevant data submitted by the NCCI to determine whether a rate change is supported. Currently, about 70 cents of every \$1 collected in premiums is projected to cover the cost of paying workers compensation claims. Approximately 27.5 percent of each dollar is used by insurance carriers to cover other costs of doing business – e.g., administrative expenses, salaries and overhead. The margin of profit is projected at roughly 2.5 percent plus the earnings on investments.

After reviewing the rate filing, the commissioner of insurance generally approves an "overall" statewide premium change. This "overall" change is stated as a percentage (for example, a five percent overall increase); however, individual classification base rates may increase or decrease more than the "overall" change. Individual classification base rates must continue to reflect the experience (premiums and losses) of employers in each classification.

Premium Components

Workers compensation insurance premiums are calculated based on several factors. The primary factors are:

Base rate: the starting point in calculating premiums. The base rate or loss cost is filed by NCCI and all carriers are required to use it. The base rates can change annually due to statewide loss experience of all employers in the same classification. The companies multiply the base rate by their approved Loss Cost Multiplier (LCM) in order to determine the rate per \$100 of payroll.

Classification: a key factor in determining what rate an employer will pay. Classification denotes the employer's type of business; hazardous jobs are more likely to result in substantial and costly claims and, therefore, usually have a higher rate. There are about 600 classifications in use in Kansas.

Experience rating: affects premium based on the frequency and severity of compensation claims of employers with sufficient premium size to be "experience rated." Currently, employers with an annual premium of at least \$4,500 within the past two years, or if more than two years, an average annual premium of \$2,250 or more are experience rated. Fewer and less expensive claims mean a lower experience modification factor, which means a lower premium.

Payroll size: employers with larger payrolls generate more workers compensation annual premiums than those with a smaller payroll in the same classification. However, the expenses incurred in issuing and servicing the policy do not increase in direct proportion to the policy premium. Consequently, a premium discount may be applied to policies with a larger premium to recognize this factor.

Also, some employers are subject to fixed payroll amounts. Partners, sole proprietors and members of a limited liability company who elect to cover themselves under a workers compensation insurance policy pay a premium based on a set payroll which is adjusted annually. The premium for an executive officer of a corporation is based on the actual payroll of the officer, subject to a set per-week minimum and maximum payroll which may be adjusted annually.

Factors Affecting Premiums

Three of the most important factors in reducing premiums are:

- Implementation of an accident prevention program:** these programs were mandated by 1993 legislation and are to be made available to employers by all insurance carriers and group-funded pools operating in Kansas. Because accident prevention programs have been shown to reduce the frequency and severity of injuries, they offer employers the potential to reduce premiums. Premium reduction is, of course, only one benefit of accident prevention that employers should consider.
- Assuring the proper classification(s) was used to calculate the premium:** the classification used on the policy should, as reasonably and accurately as possible, describe the employer's business and the employee's duties. The use of an inappropriate classification could result in the payment of an incorrect premium. If a classification does not seem to accurately describe a particular job, assistance in verifying that the proper classification was used or in obtaining a correction is available by calling the Insurance Department: (800) 432-2484 or (785) 296-3071, or visiting the website at www.ksinsurance.org.

3. **Use of deductible:** deductibles can be a cost-effective means of reducing premiums and are available in various amounts. Losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification. The insurer shall pay the deductible amount and seek reimbursement from the insured employer for the applicable deductible amount.

General Information

How to Obtain Insurance

Workers compensation insurance coverage can be obtained by:

- contacting a licensed insurance agent;
- contacting the Kansas Insurance Department for information on group-funded pools; or
- contacting the Division of Workers Compensation for information on self-insurance.

Kansas Workers Compensation Insurance Plan (Assigned Risk Plan)

Any employer who is in good faith entitled to but unable to purchase coverage in the voluntary workers compensation insurance market can obtain coverage in the Assigned Risk Plan. This means an employer is assigned to an insurance carrier who is authorized to provide coverage. Assigned Risk Plan premiums are calculated using the same loss costs as if the coverage were purchased in the voluntary market; however, premiums may be higher due to differentials applied to assigned risk rates and individual employer loss experience.

For assistance and questions about the Assigned Risk Plan, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Insurance Rating Appeals Process

If an employer suspects the wrong classification or other incorrect factor is being used in calculating a premium, the rating may be appealed in writing to the insurance carrier from which the coverage was purchased. The employer may also appeal in writing to the Kansas Commissioner of Insurance by outlining the nature of the complaint or appeal.

For additional information, or for assistance in appealing or correcting a classification error or other rate problem, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Division of Responsibilities

Responsibilities of the Employee:

- Notify your employer immediately. Per K.S.A. 44-520, for injuries on or after May 15, 2011, and before April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
 - 30 calendar days from the date of accident or the date of injury by repetitive trauma;
 - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
 - 20 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Per K.S.A. 44-520, for injuries on or after April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
 - 20 calendar days from the date of accident or the date of injury by repetitive trauma;
 - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or

- 10 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.
- Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.
- The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the Workers Compensation Act or has suffered a work- related injury.

Responsibilities of the Employer:

- Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.
- The employer/carrier must file accident report with the division within 28 days from the date of employer's knowledge of injury.
- **The employer is required** by K.S.A. 44-5, 102(a) to deliver information immediately to employee or legal beneficiary to assist in the claims process (material is available from the employer's carrier or the Division of Workers Compensation), including form K-WC 27 or K-WC 27-A, or K-WC 270 or K-WC 270-A (Spanish).

Responsibilities of the Division of Workers Compensation:

- Makes official record of accident reports filed with the division.

Survivors' Benefits

The workers compensation law provides for survivors' benefits in the event of an employee's job- related death. Survivors do not need to be U.S. citizens or reside in the United States to receive compensation.

The weekly benefits are based on 66.67 percent of the employee's average weekly wage at the time of the accident or injury, but cannot exceed the statutory **maximum**. The **minimum** death benefit is 50 percent of the state's average weekly wage in effect on the date of accident. Total compensation benefits may not exceed \$300,000, unless benefits are being paid to a dependent child under the age of 18.

Funeral expenses up to \$5,000 and all medical and hospital expenses related to the fatal injury are also covered.

An initial payment of \$40,000 must be made to the surviving legal spouse or wholly dependent child(ren) or divided among them, 50 percent to the surviving legal spouse and 50 percent to the dependent children. This \$40,000 payment is not subject to the eight percent discount normally allowed for lump sum payments. The initial payment shall be paid immediately.

Spouse and Children

If an employee is survived by a spouse but no dependent children, the spouse receives the entire weekly benefit. If an employee is survived by a spouse and children, the weekly benefit is paid half to the spouse and half to the children. If an employee is survived only by children, the weekly benefit is divided equally among the children.

Dependent children receive benefits until age 18, or until age 23 if they are full-time students or mentally or physically disabled, even if the benefits exceed the statutory limit at the time of the accident. Where required, the employer shall pay the costs of a court appointed conservator not to exceed \$1,000.

Other Dependents

If survivors' benefits are paid to the spouse and/or children, they may not be paid to any other beneficiaries. In the case of unmarried employees leaving no dependent children, any other dependents who were wholly or partially dependent upon the employee may receive compensation.

Dependents other than spouse or children may collect weekly benefits subject to the maximum of \$18,500, until they die, remarry or receive more than 50 percent of their support from another source.

Legal Heirs

If the employee leaves no spouse, dependent children or other dependents either wholly or partially dependent upon the employee, a lump sum payment of \$25,000 shall be made to the legal heirs of the employee.

Conditions Affecting Benefits

Drugs and Alcohol

An employer is not liable for workers compensation benefits if an employee is impaired due to the use of alcohol* or drugs** and the impairment contributed to injury or death. This includes the use of prescription or non-prescription medications; benefits may be allowed, however, if:

- the drugs or medications were taken in therapeutic doses; and
- the employee had not been impaired on the job from such medications within the past 24 months.

If it is shown that the employee was impaired at the time of the injury, there shall be a rebuttable presumption that the accident, injury, disability or death was contributed to by such impairment.

An employee's refusal to submit to a chemical test at the request of the employer shall result in the forfeiture of benefits under the Workers Compensation Act if the employer had sufficient cause to suspect the use of alcohol or drugs by the claimant, or if the employer's policy clearly authorizes post- injury testing.

The results of a chemical test shall be admissible evidence to prove impairment if the employer establishes that the testing was done under any of the following circumstances:

1. as a result of an employer-mandated drug testing policy, in place in writing prior to the date of accident or injury, requiring any worker to submit to testing for drugs or alcohol;
2. during an autopsy or in the normal course of medical treatment for reasons related to the health and welfare of the injured worker and not at the direction of the employer;
3. the worker, prior to the date and time of the accident or injury, gave written consent to the employer that the worker would voluntarily submit to a chemical test for drugs or alcohol following any accident or injury;
4. the worker voluntarily agrees to submit to a chemical test for drugs or alcohol following any accident or injury; or
5. as a result of federal or state law, or a federal or state rule or regulation having the force and effect of law, requiring a post-injury testing program and such required program was properly implemented at the time of testing.

*An employee is considered to be impaired from alcohol if the blood alcohol concentration at the time of injury is .04 or more.

** Confirmatory test cutoff levels (ng/ml)

Marijuana metabolite	15	Opiates:	
Cocaine metabolite	150	Morphine	2000
Amphetamines:		Codeine	2000
Amphetamine	500	6-Acetylmorphine	10ng/ml
Methamphetamine.....	500	Phencyclidine	25

Safety Violations: K.S.A. 44-501(a)(1)

Compensation for an injury shall be disallowed if such injury to the employee results from:

1. the employee's deliberate intention to cause such injury;
2. the employee's willful failure to use a guard or protection against accident or injury which is required pursuant to any statutes and provided for the employee;
3. the employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer;
4. the employee's reckless violation of their employer's workplace safety rules or regulations; or
5. the employee's voluntary participation in fighting or horseplay with a co-worker for any reason, work related or otherwise.

The preceding shall not apply when it was reasonable under the totality of the circumstances to not use such equipment, or if the employer approved the work engaged in at the time of an accident or injury to be performed without such equipment.

Coronary Disease and Stroke

The law does not provide compensation for coronary or coronary artery disease or cerebrovascular injury (e.g., stroke), unless it is shown that the exertion of the work that caused the injury was beyond that required by the employee's usual job duties. Another exception is vascular injury caused by extreme heat.

Prior Disability Ratings/Pre-existing Condition

Compensation for any permanent disability may be reduced by the existence of a rating on any applicable pre-existing disability.

K.S.A. 44-501(e): An award of compensation for permanent partial impairment, work disability or permanent total disability shall be reduced by the amount of functional impairment determined to be pre-existing. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

K.S.A. 44-501(e)(1): Where workers compensation benefits have previously been awarded through settlement or judicial administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be pre-existing. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of pre-existing functional impairment shall be established by competent evidence.

Guidelines for Obtaining Medical Treatment

Who Pays?

Employers are responsible for all medical treatment necessitated by a job-related injury or disease. This includes:

- services of a licensed health care provider;
- surgical, hospital and other medical treatment;
- medications, medical and surgical supplies;
- nursing services;
- crutches and other medical apparatus;
- ambulance services; and
- transportation between the employee's home and the place of medical treatment, subject to a minimum of five miles round trip.

If an employer has workers compensation insurance, the insurance carrier is required to pay for applicable medical expenses. Uninsured employers subject to workers compensation laws are still responsible for the medical bills of covered employees.

Employers are legally entitled to choose the treating physician. If an employee self-selects a physician who is not authorized or agreed upon by the employer, the employer is responsible for only the first \$500 in medical bills from such self-selected physicians.

Employer-Ordered Examinations

After obtaining whatever emergency medical care is necessary, an employee shall submit to any reasonable physical examination ordered by the employer. The employer can also require the employee to submit to ongoing examinations – up to twice monthly, or more often if specifically ordered by the Division of Workers Compensation. Employees may forfeit the benefits that are available if they refuse to submit to such examinations. Employees are entitled to know the results of any physical examination ordered by the employer. At the employee's request, the doctor conducting the examination must furnish the employee, within a reasonable time after the examination, a report identical to that sent to the employer or the employer's carrier. Employees are entitled to have their own doctor present at, and participate in, any medical examination ordered by the employer. If this is not allowed, or if employees are not furnished a copy of the medical report, then the examination ordered by the employer will not be allowed as evidence related to the claim.

Fraud and Abuse

Both the Division of Workers Compensation and the Kansas Insurance Department have units dedicated to the investigation of fraudulent or abusive acts and practices that occur with regard to the Workers Compensation Act. Acts or conduct that are considered to be fraudulent or abusive can generally be described as situations in which claimants, employers or companies fail or refuse to follow directives of the Workers Compensation Act. The Workers Compensation Act applies to the following:

- persons claiming benefits under the Workers Compensation Act;
- employers subject to the requirements of the Workers Compensation Act;
- insurance carriers and group-funded self-insurance plans providing coverage for work-related injuries;
- any person, corporation, business or health care facility providing treatment for work-related injuries;
- attorneys and other representatives of employers, employees, insurers or other entities involved in the administration of the Workers Compensation Act.

If the director, or the assistant attorney general assigned to the Division of Workers Compensation, has probable cause to believe a fraudulent or abusive act or practice that violates the Workers Compensation Act has occurred, a copy of any order and all investigative reports and any evidence in the possession of the Division of Workers Compensation which relates to such act shall be forwarded to the prosecuting attorney of the county in which the act occurred.

Any person who believes a violation of the Workers Compensation Act has occurred may notify the Division of Workers Compensation immediately and should send the information relating to the alleged violation to the division. The director shall evaluate the facts surrounding the alleged violation to determine the extent, if any, to which violations of the Workers Compensation Act exist. For more information, call (785) 296-4000 or (800) 332-0353; or send email to wcfraud@dol.ks.gov.

Any person who has a complaint against an insurance company, or other person/entity regulated by the Kansas Insurance Department, regarding the handling of a workers compensation claim, should contact the Anti-Fraud Division at the Kansas Insurance Department. Complaints may be made by calling (800) 432-2484 or (785) 296-3071, in writing by sending information to the Anti-Fraud Division at 420 SW 9th, Topeka, KS 66612 or online at www.ksinsurance.org.

Coverage and Compliance

The Compliance section monitors and assists employers to ensure that they fulfill two requirements under the Workers Compensation Act:

1. to secure workers compensation benefits for employees and
2. to file written reports of alleged work accidents.

Failure to secure workers compensation benefits or report accidents can result in monetary penalties against the employer. Failure to secure workers compensation benefits can also result in closure of the business.

All employers are required to report any accident alleged to have occurred in the course of employment, that wholly or partially incapacitates the worker from labor or service for more than the day, shift or turn on which the alleged accident occurred. The accident report must be filed with the Division of Workers Compensation within 28 days after the employer receives knowledge of the accident.

When the director has reason to believe an employer has engaged in the knowing and intentional failure to secure the payment of workers compensation to its employees, the director shall issue and serve upon such employer a statement of the charges and shall conduct a hearing in accordance with the Kansas Administrative Procedure Act. The employer may be liable to the state for a civil penalty in an amount equal to twice the annual premium or \$25,000, whichever amount is greater.

The director shall order employers to come under the Workers Compensation Act by:

1. insuring and keeping insured the payment of such compensation with an insurance carrier authorized to transact the business of workers compensation insurance in the state of Kansas;
2. showing to the director that the employer carries such employer's own risk and is what is known as a self-insurer and by furnishing proof to the director of the employer's financial ability to pay such compensation for the employer's self; or
3. maintaining a membership in a qualified group-funded workers compensation pool. The cost of carrying such insurance or risk shall be paid by the employer and not the employee.

For more information, call (785) 296-4000 or (800) 332-0353; or send email to wccompliance@dol.ks.gov or go to www.dol.ks.gov.

Verify Coverage

You can check whether a business has workers compensation coverage [online](#). The website provides public access to portions of the information reported by private workers compensation insurance carriers for use by the Kansas Department of Labor (KDOL). The accuracy of data from any third party cannot be guaranteed by the agency and KDOL is not responsible for the coverage information available through this link.

For additional help with verifying workers compensation coverage in Kansas, call Workers Compensation Coverage and Compliance at (785) 296-4000.

Safety and Health Services

Workplace safety and accident prevention is a key element of the law. This requirement was designed to reduce claims/losses which would hold down premiums for employers. Because rates are based on losses, the prevention of employee accidents through enhanced safety measures is one of the best ways employers can help keep rates down.

By law, insurance carriers and group-funded plans must provide accident prevention programs upon request to their insureds. Notice of such accident prevention programs must appear on the front page of every policy issued after July 1993.

Programs Offered by the Kansas Department of Labor

Consultation: offers assistance to private sector employers in safety and health program evaluations. Consultants offer advice in the recognition, evaluation and control of hazards in the workplace. Assistance with program initiation and development is available. Training, both formal and informal, is performed in all areas of safety and health. All services are at no cost to the client.

Public Sector Compliance: monitors the public sector – cities, counties, state agencies and school districts – by performing compliance audits under [K.S.A. 44-636](#) and/or [K.S.A. 44-575\(f\)](#). Occupational hazards are identified and program elements are assessed. Hazards must be abated within 60 days. Investigations of employee complaints, near misses and fatalities are also conducted.

Accident Prevention: evaluates insurance companies and group-funded self-insurance plans to ensure that they are offering and providing safety and health services at no charge to their insureds as required by law. The quality and quantity of these services are evaluated by trained consultants by directly reviewing insurance company records and contacting those insured who have requested and been provided services.

Safety and Health Conference: the annual Kansas Safety and Health Conference brings industrial, academic, vendor and government safety representatives together. The conference is self-supporting and seeks to address the relevant safety issues in a variety of workshops and presentations.

Workplace safety and health assistance is available by calling (785) 296-4386 or by emailing indsafetyhealth@dol.ks.gov. You can also find information online under Workplace Safety at www.dol.ks.gov.

Ombudsman Services

The Kansas Division of Workers Compensation established a Claimant Advisory Section in 1978. In 1993 the Legislature followed a national trend and, by statute, created the ombudsman program. The workers compensation reform legislation of 1993 mandated an expanded role for the Claims Advisory Section to enable a more proactive approach to assisting all parties in understanding their rights and responsibilities under the Workers Compensation Act.

The division employs full-time personnel who specialize in aiding injured workers, employers and insurance professionals with claims information and problems arising from job-related injuries and illnesses. The ombudsman acts in an impartial manner and is available to provide the parties with information about the current issues within the workers compensation system. For example, the ombudsman has current information on legislative changes or changes due to decisions made by the Workers Compensation Board or the courts. The ombudsman section also can assist with specific issues on current workers compensation claims.

Assisting Injured Workers with:

- Providing general information
- Obtaining medical treatment
- Benefits not being paid or not being paid on a timely basis
- Unpaid medical benefits
- Calculations of benefits
- Timely notification of employer
- Procedures for filing for a hearing
- Obtaining survivors' benefits
- Informal dispute resolution
- Mediation assistance
- Interpretation for Spanish-speaking workers

Assisting Employers/Insurance Companies with:

- Providing general information
- Posting Workers Compensation Notice ([K-WC 40](#) and [K-WC 40-A](#))
- Providing required information to injured workers ([K-WC 27](#) or [K-WC 27-A](#), or [K-WC 270](#) or [K-WC 270-A](#))
- Timely submission of accident reports
- Timely and appropriate payment of medical services
- Election information
- Assistance with death benefit requirements
- Informal dispute resolution
- Assistance with Spanish-speaking workers

- Employer staff training on workers compensation issues
- Site visits for hands-on assistance

Ombudsman assistance is available either in person or by calling (785) 296-4000 or (800) 332-0353. You also may send an email to wc@dol.ks.gov. Additionally, forms are available for download at www.dol.ks.gov.

Employer Services Unit

For technical assistance, and presentations and training for employers, call (785) 296-4000 or (800) 332-0353, or email wcemployerservices@dol.ks.gov.

Mediation

Mediation was legislatively created in 1996 ([K.S.A. 44-5,117](#)) and can be utilized at any point during the workers compensation process. The statute was amended in 1998 to allow mediation by video conferencing. Mediation is not mandatory or a prerequisite to a hearing and it may be utilized at any time during the worker compensation process. The issues that can be mediated are not restricted to medical or temporary total disability benefits.

What Is Mediation?

Mediation is a means of resolving disputes in an informal and non-adversarial atmosphere. The parties to a dispute use a neutral third party to facilitate the discussion. The mediator has no decision making authority or interest in the outcome to the dispute. The mediator's job is to assist the parties in identifying the issues in dispute and establishing common goals. The key to mediation is allowing the parties to work through their dispute and create their own agreements (self-determination).

Who Are the Mediators?

The mediators are employees of the Division of Workers Compensation who have received special training in the process of mediation. The mediators used by the Division of Workers Compensation meet or exceed the requirements established by [K.S.A. 5-501](#) and amendments thereto, and any relevant rules of the Kansas Supreme Court as authorized pursuant to [K.S.A. 5-510](#), and amendments thereto. Mediators receive training in conflict resolution techniques, neutrality, agreement writing, ethics, role playing, communication skills, evaluation of cases and the laws governing mediation.

Representation and Assistance

Any party may be represented by an attorney at this mediation conference or may request assistance from the Ombudsman/Claims Advisory section. The absence of an attorney during the process does not mean legal representation cannot be obtained later if the dispute is not settled in this informal setting.

For additional information or to schedule a mediation conference, please call (785) 296-4000 or (800) 332-0353. Write to Mediation Section, Kansas Department of Labor, Division of Workers Compensation, 401 SW Topeka Blvd., Topeka, KS 66603-3182. You may send email to wcmediation@dol.ks.gov.

Medical Services

The primary function of the Medical Services section is the administration of the Schedule of Medical Fees. The fee schedule is updated and revised on an annual basis to promote health care cost containment, yet insure the availability of necessary treatment and care for injured employees.

The Medical Services section is available to act as a liaison between health care providers, employers, employees, insurance carriers, group-funded pools or self-insured businesses. Additionally, the section conducts informal hearings to assist in the resolution of disputed medical claims and related payments involving health care providers.

For assistance in resolving issues related to fee schedule interpretation, payment disputes, etc., contact the Medical Services section at (785) 296-4000 or fax (785) 296-0025.

Vocational Rehabilitation

Vocational rehabilitation may be provided at the option of the employer or the employer's insurance carrier. General experience has shown that the longer the length of time away from work recovering from an injury, the greater the likelihood that an employee will need vocational rehabilitation to resume suitable work at comparable pay.

If the employer or insurance carrier does not choose to provide for vocational rehabilitation, the employee can ask the rehabilitation administrator for a referral to a provider of such services, at the employee's expense. The employee can also request a referral to the Division of Rehabilitation Services in the Kansas Department of Social and Rehabilitation Services.

For assistance with vocational rehabilitation, contact the rehabilitation administrator's office in the Division of Workers Compensation at (800) 332-0353 or (785) 296-4000 or send email to wcrehab@dol.ks.gov.

**Kansas Department of Labor
Division of Workers Compensation**

Kansas Department of Insurance

A T E N C I Ó N

INFORMACIÓN IMPORTANTE PARA TRABAJADORES LASTIMADOS EN EL TRABAJO

Llame a los: Consultivos de Reclamacion/Ombudsman

Llamada Gratis 1-800-332-0353

O Escriba A:
DIVISION OF WORKERS COMPENSATION
800 SW JACKSON STREET SUITE 600
TOPEKA, KS 66612-1227

Si Ud. se ha lastimado a causa de su trabajo, y tiene algunas preguntas con respecto a los beneficios de la Compensación de Trabajadores, comuníquese con la SECCIÓN DE CONSULTIVOS DE RECLAMACIÓN/ "OMBUDSMAN" del Departamento de Compensación Para Trabajadores de Kansas. Este departamento mantiene a su disposición algún personal que se especializa en dar asistencia con los problemas de reclamación y en dar información sobre los reclamos, a los trabajadores lastimados que tiene derecho a recibir. También pueden asistirle en resolver los problemas con respecto a los beneficios que no se le están pagando a tiempo, al tratamiento médico, a las cuentas de los doctores que aún no se han pagado, y también con preguntas respecto a la cantidad del arreglo de resolución llamado "settlement". Intérpretes en Español están a su disposición en el Departamento de Compensación de Trabajadores.

¿QUÉ DEBE HACER SI LE SUCEDE UN ACCIDENTE A CAUSA DEL TRABAJO?

1. Avísele inmediatamente al patrón, o a su empleador, que Ud. se ha lastimado a causa de su trabajo. (DENTRO DE 10 DÍAS DEL ACCIDENTE).
2. Siga las instrucciones del patrón, o el empleador, con respecto al tratamiento médico, y siga las instrucciones del doctor médico.
3. Dentro de 200 días del accidente, o del último día en que le pagaron compensación por estar incapacitado, o en que recibió tratamiento médico autorizado, avísele al patrón o al empleador POR ESCRITO que Ud. espera recibir los beneficios de compensación de trabajadores, por su accidente. Aunque su patrón ya se haya informado del accidente, y ya le esté pagando los beneficios, Ud. puede perder el derecho de recibir compensación en el futuro, si no le avisa al patrón o al empleador POR ESCRITO. Esta documentación es lo que se nombra un "AVISO POR ESCRITO" o "WRITTEN CLAIM." El "Aviso Por Escrito" se puede entregar al empleador o al patrón de dos maneras diferentes: Se lo puede entregar en persona, y al mismo tiempo que se lo entrega, pídale al patrón un recibo. También se lo puede enviar por correo certificado, pida que el correo le devuelva a Ud. un recibo indicando el nombre y la firma de la persona que recibió el aviso por correo. Ese recibo del correo normalmente es suficiente para comprobar que Ud. envió el "Aviso Por Escrito."

PROMEDIO DEL SUELDO SEMANAL: Para calcular un promedio del sueldo semanal "average weekly wage" del trabajador, se suman todos los siguientes: el sueldo básico, más un promedio de las horas extras (overtime) que se trabajan por semana, más el valor semanal de cualquier beneficio adicional que haya sido descontinuado.

BENEFICIOS SEMANALES: Los Beneficios se los paga la compañía o el grupo de Aseguración del Empleador, o el programa propio de Aseguración del Empleador. Los trabajadores que se han lastimado a causa del trabajo, no tienen derecho a recibir compensación por la primera semana en que estan sin trabajar a causa del accidente industrial, **A MENOS QUE** esten sin trabajar por orden del doctor, durante tres semanas consecutivas. El primer pago de compensación normalmente se le debe al trabajador al terminar el catorzavo día de estar sin trabajar, por orden del doctor. Un trabajador lastimado a causa del trabajo tiene derecho cada semana a una cantidad equivalente al 66 2/3% porciento del promedio de su sueldo semanal, hasta llegar a un máximo equivalente al 75% porciento del promedio de sueldos semanales designado por el Estado de Kansas. Estos beneficios están expuestos a cualquier cambio que ordene la legislatura del estado. Si el accidente resulta en una incapacidad de modo permanente, la ley de compensación en Kansas le da derecho a otros beneficios adicionales.

BENEFICIOS MEDICOS: Un trabajador lastimado a causa del trabajo tiene derecho a todo servicio médico razonable y necesario para curar y aliviar al trabajador de los efectos del accidente. El patrón, o el empleador, tiene derecho a escoger el doctor autorizado para darle tratamiento médico al trabajador. Aún así, el trabajador tiene derecho de escoger los servicios de otro doctor que no sea autorizado hasta llegar al límite máximo de \$500.00 dólares. Un trabajador puede pedirle al Director del Departamento de Compensación de Trabajadores que le cambie el doctor autorizado. También tiene derecho de pedir recompensación de la cantidad de gastos de viajes necesarios que haya hecho de mas de cinco (5) millas, para obtener tratamiento médico de un accidente industrial. El porcentaje que se puede recompensar se establece por ley.

RESPONSABILIDADES DEL EMPLEADOR (EL PATRÓN):

1. El empleador debe reportar cada accidente industrial de los trabajadores al Departamento de Compensación de Trabajadores, dentro de 28 días de la fecha del accidente, o de la fecha en que el empleador se haya dado cuenta del accidente.
2. El empleador debe suministrar el pago de las reclamaciones sin cobrarle a los trabajadores que hacen los reclamos de beneficios.
3. El empleador debe exhibir **AVISOS POR ESCRITO** en Ingles y en Espanol, avisándoles a los trabajadores del Aseguración de Compensación de Trabajadores que tiene el empleador.
4. El empleador debe pagar los beneficios de compensación aunque no tenga aseguración.
5. En cuanto reciba aviso de un accidente, el empleador o patrón debe proporcionarle al trabajador información escrita, dándole asistencia al trabajador en la reclamación de los beneficios.

LOS EMPLEADORES (EL PATRÓN) DEBEN COMPLETAR LA SIGUIENTE INFORMACION PARA CADA TRABAJADOR LASTIMADO A CAUSA DEL TRABAJO:

ESTA PERSONA NOMBRADA SE ENCARGARÁ DE SU RECLAMO:

La Compañía Es: _____

El Domicilio Es: _____

Póngase En Contacto Con Esta Persona: _____

Llame a Este Telefono: _____ (_____)



**Información de
Compensación
De Trabajadores para
Empleadores y Empleados
del Estado de Kansas**



Copias de las formas de elección, reportes de accidente, exhibición de aviso (K-WC 40 y K-WC 40-A) y todos los demás carteles obligatorios están disponibles para descargarse en www.dol.ks.gov.

Para obtener información adicional sobre los beneficios de compensación de trabajadores, directrices para empleadores y otra información general, contacte:

Departamento de Laboral de Kansas
División de Compensación de Trabajadores
401 SW Topeka Blvd.
Topeka, Kansas 66603
(785) 296-4000
(800) 332-0353
Correo electrónico: wc@dol.ks.gov
Sitio en internet: www.dol.ks.gov

Para más información en tarifas de seguro para compensación de trabajadores y conducta de compañías aseguradoras, contacte:

Departamento de Seguros de Kansas
420 S.W. 9th St. Topeka,
Kansas 66612-1678 (785)
296-3071
(800) 432-2484

Correo electrónico: commissioner@ksinsurance.org
Sitio en internet: www.ksinsurance.org

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¿Qué es Compensación de Trabajadores?

Compensación de trabajadores es un plan de seguro requerido del empleador para pagar beneficios al empleado por lesiones relacionadas con el trabajo, incapacidad o muerte que surgen de y en el curso del empleo.

De acuerdo al artículo de ley K.S.A. 44-508, se considerará que una lesión por accidente surge del empleo si:

- Hay una conexión casual entre las condiciones bajo las cuales el trabajo es requerido a ser realizado y el accidente resultante; y
- El accidente es el factor predominante causando la lesión, condición médica y la resultante discapacidad o impedimento físico.

Las palabras "surgen de y en el curso del empleo" como se usan en la ley de compensación de trabajadores no se interpretarán para incluir:

- Lesión que se produjo como resultado del proceso de envejecimiento natural o por las actividades normales del vivir diario;
- Accidente o lesión que surgió de un riesgo neutral sin empleo particular o de carácter personal;
- Accidente o lesión que surgió de un riesgo personal para el trabajador; o
- Accidente o lesión que surgió directa o indirectamente por causas desconocidas.

Los beneficios son pagados a expensas del empleador. La cobertura empieza el primer día de trabajo.

La presente ley abarca todos los empleadores de Kansas excepto aquellos en ciertas actividades agrícolas o aquellos con una nómina anual bruta de 20,000 dólares o menos. Toda nómina es tomada en cuenta, incluyendo la que es pagada en Kansas o en otras partes. Si el empleador es un único propietario o una miembro de una asociación, los salarios pagados a los propietarios y a cualquiera de sus familiares no se utilizan en el cálculo de la nómina anual bruta.

Los empleados discapacitados debido a una enfermedad o lesión relacionada con el trabajo tienen derecho a:

- gastos médicos para tratar la lesión relacionada con el trabajo o la enfermedad; y
- beneficios de ingresos para sustituir parte del salario perdido debido a la discapacidad.

Si muerte resulta de una enfermedad o lesión relacionada con el trabajo, podrán pagarse beneficios al cónyuge sobreviviente, dependientes o herederos.

Propósito de la ley

Kansas pasó su primera ley de compensación trabajadores en el año de 1911. Mediante la regulación de los litigios y los beneficios, la ley está diseñada para proteger los intereses de los empleadores y empleados. Los empleadores se benefician mediante sustituir un gasto conocido (primas) por el riesgo a largo plazo de gastos no presupuestados, en caso de discapacidad grave del empleado. Los empleados se benefician debido a que la negligencia del empleador no es una cuestión en la determinación de responsabilidad. Cobertura de compensación de trabajadores es un sistema sin culpa. Las disposiciones de la Ley de Compensación de Trabajadores se aplicarán imparcialmente a los empleadores y empleados. Aunque inicialmente la ley estaba destinada a trabajos peligrosos, ahora cubre a la mayoría de los trabajadores.

Elecciones

Elecciones dentro o fuera de la Ley de Compensación de Trabajadores son opciones disponibles para los empleadores o empleados. Dependiendo de las circunstancias, las opciones pueden estar disponibles para:

- empleadores no cubiertos: por ejemplo, aquellos con nóminas de 20,000 dólares o menos o en ciertas actividades agrícolas;
- empleados de una corporación dueños de 10 por ciento o más de las acciones;
- individuos, propietarios o asociaciones;
- empleadores buscando cobertura para voluntarios y otros trabajadores no cubiertos; y
- directores voluntarios, funcionarios o administradores de una organización sin fines de lucro.

Ejemplo: Una asociación de dos personas tiene dos empleados: un miembro de la familia y uno que no es miembro de la familia: y una nómina anual de 15,000 dólares. La asociación puede optar por adquirir la cobertura bajo la ley y extender dicha cobertura a ambos empleados. Los socios no están cubiertos porque son considerados como el empleador.

Formas de elección pueden encontrarse en el Internet en www.dol.ks.gov.

Derechos y Responsabilidades de los Empleados

La Ley del estado de Kansas protege el derecho del empleado y facilita la obtención de compensación del trabajador. Específicamente:

- Un empleado no puede ser despedido, degradado o discriminado de cualquier otra manera por la presentación de un reclamo en buena fe.
- Los empleados deben ser informados de sus derechos y responsabilidades en caso de lesión. En el caso de muerte del empleado, dicha información deberá aportarse a los beneficiarios del empleado.
- No se debe imponer un pago a los empleados para reclamos de compensación de trabajadores. Los empleadores no puede deducir del sueldo o de los beneficios para pagar las primas de seguros o reclamos.
- Empleados pueden tener derecho a beneficios de compensación de un empleador sujeto a la Ley independientemente de la cobertura del seguro.
- Empleados pueden obtener asistencia gratuita mediante ponerse en contacto con la oficina Ombudsman de Compensación de Trabajadores a los teléfonos (800) 332-0353 o (785) 296-4000.
- La ley estipula sanciones específicas por fraude tanto a empleados como empleadores en casos de compensación de trabajadores. Para más información o asistencia, o para reportar sospecha de fraude, póngase en contacto con la Oficina Ombudsman de Compensación de Trabajadores o la Oficina de Fraude y Abuso a los teléfonos (785) 296-4000 o (800) 332-0353.

Responsabilidades del Empleador

Seguro de Compensación de Trabajadores

La mayoría de los empleadores están obligados por ley a proveer el pago de reclamos de compensación de trabajadores, sin ningún costo para el empleado. Los empleadores deberán cumplir con este requisito de tres maneras:

- Seguro de compensación de trabajadores: obtenida de una compañía de seguros con licencia; el empleador paga las primas y la compañía de seguros paga los reclamos. Las compañías de seguros son reguladas por el Departamento de Seguros del estado de Kansas.
- Auto-seguro: un empresario individual debe demostrar al Estado de Kansas la capacidad financiera para pagar cualquier reclamo que pudiera surgir. Este programa es administrado por la División de Compensación de Trabajadores.
- Grupo financiero de fondo común: un grupo de empresarios que cumplen ciertos requisitos legales pueden formar un programa de auto-seguro para asegurar conjuntamente su capacidad para pagar los reclamos. Este programa es administrado por el Departamento de Seguros del estado de Kansas.
- Falta deliberada de proveer el pago de compensación de trabajadores en una de las formas anteriores es un delito menor, clase A y somete al empleador a una pena civil en una cantidad dos veces la prima anual que el empleador hubiera pagado por seguro o 25,000 dólares, cualquiera de las cantidades que sea mayor.

Categorías de empleo excluidos de la ley son:

- ciertas actividades agrícolas;
- agentes inmobiliarios que califican como contratistas independientes;

- empleadores con nóminas anuales brutas de 20,000 dólares o menos;
- bomberos pertenecientes a una asociación de socorro de bomberos que ha renunciado la cobertura bajo la Ley de Compensación de los Trabajadores; y
- ciertos conductores de vehículos que son propietarios y que están cubiertos por su propia póliza de seguro de accidente laboral.

Otros Requisitos

- Los empleadores deben exponer el aviso escrito (K-WC 40 y K-WC 40-A), comunicando a los empleados qué hacer en caso de un accidente.
- Los empleadores deben presentar o causar que se presente un reporte de accidente con la División de Compensación de Trabajadores dentro de 28 días a partir de la fecha de la lesión reportable, muerte o notificación al empleador de lo mismo. No hacerlo puede resultar en sanciones legales y financieras.
- Inmediatamente al enterarse de la lesión o la muerte de un empleado, el empleador deberá suministrar información por escrito al empleado o a los dependientes del empleado sobre los beneficios disponibles, el proceso de reclamo, el empleador o compañía de seguros de contacto para reclamos de compensación de trabajadores y otros asuntos como es requerido por la ley. Las formas K-WC 27/27-A y K-WC 270/270-A (en español) están disponibles en internet, en el sitio de la División de Compensación de Trabajadores en: www.dol.ks.gov.
- Un empleador con seguro o auto-asegurado deberá suministrar el siguiente aviso a un trabajador asegurado o con el primer cheque de beneficios de incapacidad temporal: Advertencia: aceptación de empleo con un empleador diferente que requiere la realización de actividades que usted ha declarado que no puede realizar debido a la lesión por la que está recibiendo beneficios de incapacidad temporal puede constituir fraude y podría resultar en pérdida de beneficios en el futuro y la restitución de previas indemnizaciones y beneficios pagados.

Si necesita ayuda, llame a (800) 332-0353 o (785) 296-4000.

Categorías de Beneficios por Incapacidad

Incapacidad Total Temporal

Existe cuando el empleado, a causa de una lastimadura, no ha podido participar en cualquier tipo de empleo sustancial y remunerativo. Beneficios son pagados por la duración de la incapacidad temporal total (TTD por sus siglas en inglés). Existe un período de espera de una semana (siete días consecutivos) antes de que los beneficios temporales (TTD) sean pagados. Si la discapacidad continua por tres semanas consecutivas, el empleado es reembolsado por el período de espera. Empleados pueden obtener beneficios médicos durante la primera semana. Los beneficios temporales son 66.67 por ciento del promedio del sueldo semanal bruto del empleado, pero no menos de 25 dólares ni más que el máximo legal vigente. La compensación total no debe exceder de 130,000 dólares por lesión.

Los empleados no podrán cobrar beneficios de incapacidad total temporal y beneficios de desempleo por las mismas semanas.

Incapacidad Parcial Temporal

Existe cuando el trabajador regresa a cualquier clase de empleo ganando un sueldo inferior a aquel que tenía al tiempo de lesionarse. La compensación es calculada sobre una base semanal y se paga hasta que no hay más pérdida del sueldo o hasta que el máximo beneficio es alcanzado, lo que ocurre primero.

Los beneficios son 66.67 por ciento de la diferencia entre el salario promedio bruto semanal del empleado antes de la lesión y el salario del empleado después de la lesión pero no pueden exceder el máximo legal vigente en el estado.

Incapacidad Parcial Permanente

Existe cuando hay pérdida total o parcial del uso de una parte del cuerpo, como un brazo, debido a una lesión relacionada con el trabajo. Compensación para una incapacidad parcial permanente se limita a un porcentaje de

la tabla siguiente. Un período de curación está disponible en los casos de amputación. Los beneficios son 66.67 por ciento de un salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal de 130,000 dólares.

Lista de información de beneficios

Pérdida o pérdida del uso de:	semanas pagadas:	Pérdida o pérdida del uso de:	semanas pagadas:
Hombro	225	Dedo Pulgar	60
Brazo	210	Dedo índice	37
Antebrazo	200	Dedo medio	30
Mano	150	Dedo anular	20
Pierna	200	Dedo meñique	15
Pierna inferior	190	Dedo gordo del pie	30
Pie	125	Dedo gordo del pie (articulación de la punta)	15
Ojo	120	Cada dedo del pie	10
Oído (ambos)	110	Cada dedo del pie (articulación de la punta)	5
Oído (uno solo)	30		

Incapacidad General Parcial Permanente

Existe cuando un empleado se ha incapacitado de tal manera que es de carácter parcial y de calidad permanente y que no está cubierto por lo enlistado anterior. Por ejemplo, discapacidad envolviendo la espalda o la pérdida del uso de un hombro, brazo, antebrazo o mano, de una extremidad superior, combinada con la pérdida o pérdida uso de un hombro, brazo, antebrazo o mano, de la otra extremidad superior; o la pérdida o pérdida de uso de una pierna, pierna baja o pie, de una extremidad inferior, combinado con la pérdida de o pérdida del uso de una pierna, pierna baja o pie, de la otra extremidad inferior; o la pérdida de o pérdida del uso de ambos ojos que es parcial en carácter y permanente en calidad son discapacidades de todo el cuerpo y no están cubiertos por la lista anterior. Compensación por tales discapacidades "no programadas" o "cuerpo entero" se basa en el mayor de lo siguiente: el porcentaje de impedimento funcional; o la capacidad reducida del empleado para realizar tareas de trabajo y el sueldo semanal promedio que empleado es capaz de ganar después de la lesión. Empleados ganando 90 por ciento del sueldo que tenían antes de la lesión están limitados a impedimento funcional.

Calculando beneficios de incapacidad general parcial permanente

1. Cálculo el porcentaje de beneficio semanal mediante la identificación de la menor de estas dos cantidades: Sueldo promedio semanal bruto x 66.67 por ciento; o el máximo legal vigente.
2. Cálculo de las semanas de compensación permitidas: se empieza con 415 semanas. De las 415, se restan las semanas en que se pagó incapacidad total temporal, excluyendo las primeras 15 semanas de TTD. Se multiplica la diferencia por el porcentaje de incapacidad.
3. Cálculo del total de los beneficios: Se multiplican los beneficios semanales por el número de semanas de compensación permitidas.

Ejemplo: El sueldo promedio semanal es 875 dólares en la fecha del accidente (10/07/2011). El empleado ha cobrado 25 semanas de incapacidad total temporal (TTD) y tiene una un porcentaje de incapacidad del 25 por ciento.

Beneficio semanal: (utilice la cantidad menor)

$\$875 \times .6667 = \583.36

Máximo legal (a partir del 07/01/11) \$555

Semanas de compensación permitidas:

$415 - [25-15] = 415 - 10 = 405$ semanas

405 semanas $\times .25 = 101.25$ semanas

Cantidad de beneficio máximo:

101.25 semanas $\times \$555 = \$56,193.75$

Nuestro sitio en Internet tiene un programa de cálculo de beneficios de compensación de trabajadores. El programa de fechas le permite calcular el tiempo entre dos fechas o para calcular la suma de días a una fecha conocida. Los programas de la lista de lesiones y lesiones del cuerpo entero le permitirán calcular los beneficios de compensación a la que tiene derecho el reclamante. Se proporcionan instrucciones paso a paso para cada programa.

Incapacidad Total Permanente

Existe cuando el empleado, a causa de la lesión, ha quedado completa y permanentemente incapaz de participar en cualquier tipo de empleo remunerado y sustancial. Pérdida de ambos ojos, ambas manos, ambos brazos, ambos pies, ambas piernas o cualquier combinación de éstas, en ausencia de prueba de lo contrario, deberán constituir una incapacidad permanente total. Parálisis total considerable o imbecilidad incurable o locura, resultantes de lesiones independientes de todas las otras causas, también constituirán incapacidad total permanente.

Los beneficios son 66.67 por ciento del salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal. La compensación total no debe exceder 155,000 dólares por lesión.

Un empleado no puede recibir más de una indemnización de incapacidad total permanente en la vida.

Cómo se Determinan las Tasas de interés

El seguro de compensación de trabajadores en Kansas es obligatorio por la ley estatal para la mayoría, pero no para todos los empleadores.

Las primas pagadas por los empleadores deberían ser suficientes para cubrir los reclamos incurridos por sus compañías de seguros. Las tasas de interés se ajustan en función de las primas más recientes, los ingresos de inversión y pérdidas reportadas por las compañías de seguros. El Consejo Nacional de Seguros Compensatorios (NCCI por sus siglas en inglés) presenta estas tasas de interés anualmente al Comisionado de Seguros para su aprobación.

El Consejo Nacional de Seguros Compensatorios (NCCI) es una organización clasificadora, autorizada por el departamento de seguros, cuya composición, primordialmente consta de compañías de seguros. Ellos desarrollan el cambio necesario de la tasa de interés anual basándose en las pérdidas y primas reportadas a ellos por las compañías de seguros miembros de dicha organización.

El Departamento de Seguros de Kansas regula las tarifas que se cobran en el estado. Cada año, éste Departamento revisa las primas, los costos de los reclamos y otros datos pertinentes presentados por el NCCI para determinar si se recomienda un cambio en la tasa de interés o no. Actualmente, alrededor de 70 centavos de cada dólar recogidos en el cobro de las primas, se proyecta para cubrir el costo de pagar reclamos de compensación de trabajadores. Aproximadamente 27.5 por ciento de cada dólar es utilizado por las compañías de seguros para cubrir otros costos de hacer negocios: por ejemplo, gastos administrativos, salarios y gastos generales. El margen de beneficio se proyecta en aproximadamente un 2.5 por ciento. Además de las ganancias de las inversiones.

Después de revisar la presentación de la tasa de interés, el Comisionado de seguros generalmente aprueba un cambio "global" en la prima estatal. Este cambio "global" se expresa como un porcentaje (por ejemplo, un cinco por ciento de aumento global); Sin embargo, los tipos básicos de clasificación individual pueden aumentar o disminuir más del cambio "global". Los tipos básicos de clasificación individual deben continuar reflejando la experiencia (las primas y pérdidas) de los empleadores en cada clasificación.

Componentes de la Prima

Las primas de seguro de compensación de trabajadores se calculan basándose en varios factores. Los principales son:

Tasa de interés básica: el punto de partida para el cálculo de las primas. La tasa de interés o costo de pérdida es presentado por NCCI y todas las aseguradoras requeridas de usarla. Esta podría cambiar anualmente basada en la experiencia de la pérdida de otros empleadores en todo el estado en la misma clasificación. Las compañías multiplican la tasa de interés por su Multiplicador de Costo de pérdida aprobado para determinar la tasa de interés por cada 100 dólares de nómina.

Clasificación: un factor clave para determinar la tasa de interés que un empleador pagará. La clasificación denota la tipo de negocios; trabajos peligrosos tienen más probabilidades de provocar reclamos importantes y costosos y, por tanto, tienen una tasa de interés más alta. Hay unas 600 clasificaciones en uso en Kansas.

Clasificación basada en la experiencia: afecta la prima basada en la frecuencia y gravedad de los reclamos de compensación de los empleadores con tamaño de prima suficiente para ser "clasificados por experiencia". Actualmente, los empleadores con una prima anual de por lo menos 4,500 dólares en los últimos dos años, o si más de dos años, una prima promedio anual de 2,250 dólares o más son calificados de experiencia. Más pocos y menos costosos reclamos significan un factor modificación por experiencia más bajo, lo que significa una prima menos costosa.

Tamaño de la nómina: los empleadores con grandes nóminas generan primas anuales de compensación de trabajadores mayores que aquellos con una nómina más pequeña en la misma clasificación. Sin embargo, los gastos de distribución y abastecimiento de la póliza no incrementa en proporción directa a la prima de la póliza. En consecuencia, un descuento en la prima puede aplicarse a las pólizas con una prima más grande para reconocer este factor.

También, algunos empleadores están sujetos a cantidades de nómina fija Socios, propietarios y miembros de una compañía de responsabilidad limitada que eligen cubrirse bajo una póliza de seguro de compensación de trabajadores pagan una prima basada en una nómina fija la cual se ajusta anualmente. La prima para un funcionario ejecutivo de una empresa se basa en la nómina actual del oficial, sujeta a una nómina mínima y un máxima establecida por semana, la cual que puede ser ajustada anualmente.

Factores que Afectan a las Primas

Tres de los factores más importantes en la reducción de las primas son:

- Implementación de un programa de prevención de accidentes:** estos programas fueron ordenados por la legislatura de 1993 y están disponibles a los empleadores por todas las compañías de seguros y grupo financiado por un fondo común operando en Kansas. Porque los programas de prevención de accidentes han demostrado reducir la frecuencia y la gravedad de las lesiones, que ofrecen a los empleadores la posibilidad de reducir las primas. La reducción de la prima es, por supuesto, sólo uno de los beneficios de la prevención de accidentes que los empleadores deben tener en cuenta.
- Asegurándose que la(s) clasificación(es) adecuada(s) ha(n) sido usada(s) para calcular la prima:** la clasificación utilizada en la póliza debe describir, tan razonable y preciso como sea posible, el negocio del empleador y los deberes del empleado. El uso de una clasificación inadecuada puede resultar en pago de una prima incorrecta. Si la clasificación no parece describir con precisión un trabajo en particular, ayuda para verificar que se utilizó la clasificación adecuada o para obtener una corrección, está disponible llamando al Departamento de Seguros al teléfono: (800) 432-2484 o (785) 296-3071 o visitando el sitio en internet www.ksinsurance.org.
- Uso de deducible:** los deducibles pueden ser una manera efectiva de reducir las primas y están disponibles en diversas cantidades. No se aplicarán las pérdidas pagadas por el empleador bajo el deducible para calcular la modificación de la experiencia del empleador. El asegurador deberá pagar el importe de deducible y solicitar el reembolso del empleador asegurado por la cantidad del deducible aplicable.

Información General

Cómo Obtener un Seguro

Cobertura de seguro de compensación de trabajadores puede obtenerse por:

- ponerse en contacto con un agente de seguros con licencia;
- ponerse en contacto con el departamento de seguros de Kansas para obtener información sobre grupos financiados por el grupo; o
- ponerse en contacto con la División de compensación de trabajadores para obtener información sobre auto-seguro.

Plan de Seguro de Compensación para Trabajadores de Kansas (Plan de Riesgo Asignado)

Cualquier empresario que tenga derecho pero que no pueda adquirir cobertura en el mercado de seguros de indemnización de trabajadores voluntario, puede obtener cobertura en el Plan de riesgo Asignado. Esto significa que un empleador es asignado a una compañía de seguros que está autorizada para proporcionar cobertura. Las primas para el Plan de Riesgo Asignado se calculan utilizando los mismos costos de pérdida como si la cobertura hubiese sido comprada en el mercado voluntario; sin embargo, las primas pueden ser mayores debido a recargos adicionales que se basan en la tamaño del empleador de prima y pérdida de experiencia.

Para asistencia y preguntas relacionadas al Plan de Riesgo Asignado llame al Departamento de Seguros del estado de Kansas a los teléfonos (800) 432-2484 o (785) 296-3071.

Proceso de Apelación de Clasificación de Seguro

Si un empleador sospecha de una clasificación errónea u que otro factor incorrecto ha sido utilizado para calcular una prima, la clasificación puede ser apelada por escrito a la compañía de seguros de la que se obtuvo la cobertura. El empleador también puede apelar por escrito al Comisionado de Seguros del estado de Kansas resumiendo la naturaleza de la queja o apelación.

Para información adicional o asistencia para apelar o corregir un error de clasificación u otro problema de clasificación, comuníquese con el Departamento de Seguros de Kansas al (800) 432-2484 o (785) 296-3071.

División de Responsabilidades

Responsabilidades del Empleado:

Notificar al empleador inmediatamente. De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Mayo 15, 2011, y antes de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 30 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 20 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 20 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 10 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

El aviso podrá darse verbalmente o por escrito. Donde el aviso se proporciona oralmente, si el empleador tiene designado a un individuo o departamento a quien debe darse el aviso y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otra persona o departamento será insuficiente en esta sección. Si el empleador no ha designado a un individuo o departamento a quien debe darse aviso, el aviso debe proporcionarse a un administrador o supervisor.

Donde el aviso es provisto por escrito, aviso debe enviarse a un supervisor o gerente en la ubicación principal de trabajo del empleado.

El aviso, ya sea que se suministre oralmente o por escrito, deberá incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser evidente a partir del contenido del aviso de que el empleado está cobrando beneficios bajo la Ley de Compensación de Trabajadores o ha sufrido una lesión relacionada con el trabajo.

Responsabilidades del Empleador:

- A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero con fondos en común de la lesión del empleado.
- El empleador/compañía aseguradora debe presentar un informe de accidente con la división dentro de 28 días a partir de la fecha de conocimiento del empleador acerca de la lesión.
- El empleador es requerido por el artículo de ley, K.S.A. 44-5.102 (a) para entregar información al empleado o beneficiario legal inmediatamente para ayudar en el proceso de reclamos (material está disponible con la compañía aseguradora del empleador o en la División de Compensación de Trabajadores), incluyendo el formulario K-WC 27 o K-WC 27-A, o K-WC 270 or K-WC 270-A (español).

Responsabilidades del División de compensación de trabajadores:

- Hace el registro oficial de informes de accidentes presentados ante la División.

Beneficios para los Sobrevivientes

La ley de compensación de los trabajadores provee beneficios para sobrevivientes en caso de fallecimiento relacionado con el trabajo. Los sobrevivientes no necesitan ser ciudadanos estadounidenses o residir en los Estados Unidos para recibir compensación.

Los beneficios semanales se basan en el 66.67 por ciento del salario semanal promedio del empleado en el momento del accidente o lesión, pero no pueden exceder el **máximo** legal. El beneficio de fallecimiento mínimo es de 50 por ciento del salario semanal promedio del Estado en vigor en la fecha del accidente. Los beneficios de compensación total no puede exceder la cantidad de 300,000 dólares, a menos que se les esté pagando beneficios a dependientes menores de 18 años. Los gastos de funeral hasta 5,000 dólares, así como todos los gastos médicos y de hospital relacionados con la lesión fatal también son cubiertos.

Un pago inicial de 40,000 dólares debe ser hecho al cónyuge legal sobreviviente o niño(s) completamente dependientes o dividido entre ellos, un 50 por ciento para el cónyuge legal y 50 por ciento al (los) niño(s) dependiente(s). Este pago de 40,000 dólares no está sujeto al ocho por ciento de descuento que normalmente es permitido en los pagos globales. El pago inicial deberá ser pagado inmediatamente.

Cónyuge e Hijos

Si un empleado es sobrevivido por un cónyuge pero sin hijos dependientes, el cónyuge recibe todo el beneficio seminal. Si un empleado es sobrevivido por un cónyuge e hijos dependientes, el beneficio semanal es pagado la mitad el cónyuge, y la otra mitad a los hijos dependientes. Si un empleado es sobrevivido solo por los hijos dependientes, el beneficio semanal es dividido en partes iguales entre los hijos.

Los hijos dependientes reciben beneficios hasta la edad de 18 años, o hasta la edad de 23 años si son estudiantes de tiempo completo o están mental o físicamente discapacitados, incluso si los beneficios superan el límite legal en el momento de la accidente. Donde es requerido, el empleador deberá pagar los costos de un conservador nombrado por un tribunal sin exceder la cantidad de 1,000 dólares.

Otros Dependientes

Si los beneficios de sobrevivientes son pagados al cónyuge y/o a los hijos dependientes, no pueden ser pagados a cualquier otro beneficiario. En el caso de un empleado soltero sin hijos dependientes, otro beneficiario, dependiente total o parcialmente del empleado puede recibir la compensación.

Los dependientes que no sean el cónyuge o hijos dependientes pueden percibir los beneficios semanales hasta un máximo de 18,500 dólares, o hasta que fallezcan, se casen o reciban más del 50 de su sustento de otra fuente.

Herederos Legales

Si el empleado no deja cónyuge, hijos dependientes u otros beneficiarios ya sea total o parcialmente dependientes del empleado, un pago único de 25,000 dólares deberá ser hecho a los herederos legales del empleado.

Condiciones que Afectan los Beneficios

Alcohol y Estupefacientes

Un empleador no es responsable de beneficios de compensación de trabajadores si un empleado está incapacitado debido al uso de alcohol* o estupefacientes** y la incapacidad contribuyó a la lesión o fallecimiento. Esto incluye el uso de medicamentos con o sin receta médica; sin embargo, los beneficios pueden ser permitidos, si:

- los fármacos o medicamentos fueron tomados en dosis terapéuticas; y
- el empleado no estuvo incapacitado en el trabajo por dichos medicamentos en los últimos 24 meses.

Si se demuestra que el empleado estaba incapacitado en el momento de la lesión, deberá haber una presunción refutable de que el accidente, lesiones, discapacidad o fallecimiento fueron contribuidos por dicha deficiencia.

Si el empleado rehúsa someterse a un examen químico a petición del empleador resultará en pérdida del derecho de beneficios bajo la ley de compensación de trabajadores, si el empleador tuviera suficientes motivos para sospechar el uso de alcohol o estupefacientes por el reclamante, o si la póliza del empleador autoriza claramente las pruebas después de una lesión.

Los resultados del examen químico deberán ser evidencia admisible para demostrar la incapacidad si el empleador establece que el examen se realizó bajo cualquiera de las siguientes circunstancias:

1. como resultado de una póliza del empleador por escrito, donde es obligatorio el examen para uso de estupefacientes, establecida antes de la fecha del accidente o lesión, requiriendo a cualquier trabajador que se someta a exámenes de estupefacientes o alcohol;
2. durante una autopsia o en el curso normal de tratamiento médico por motivos relacionados con la salud y el bienestar del trabajador lesionado y no a dirección del empleador;
3. el trabajador, antes de la fecha y hora del accidente o lesión, dio el consentimiento por escrito al empleador de que el trabajador se sometería voluntariamente a un examen químico de estupefacientes o alcohol seguido de cualquier accidente o lesión;
4. el trabajador acepta voluntariamente someterse a un examen químico de estupefacientes o alcohol después de cualquier accidente o lesión; o
5. como resultado de la ley federal o estatal, o norma federal o estatal o una regulación teniendo la fuerza y efecto de la ley, requiriendo un programa de pruebas después de la lesión y dicho programa requerido fue correctamente implementado en el momento de la prueba.

*Un empleado es considerado de estar incapacitado por uso de alcohol si la concentración de alcohol en la sangre es de 0.04 o más en el momento de la lesión.

** Niveles límite de prueba confirmatoria (ng/ml)

Marihuana metabólica 15

Cocaína metabólica 150

Anfetaminas:

Anfetamina 500

Metanfetamina 500

Opiáceos:

Morfina 2000

Codeína 2000

6-Acetylmorphine 10ng/ml

Phencyclidine 25

Violaciones de Seguridad: K.S.A. 44-501(a) (1)

Compensación por una lesión deberá ser desaprobada si dicha lesión al empleado es el resultado de:

1. la intención deliberada del empleado de causar dichas lesiones;
2. falta intencionada del empleado de no utilizar una guarnición o protección contra accidentes o lesiones que es requerida en conformidad con cualquier estatuto y proporcionadas para el empleado;
3. falta intencionada del empleado para utilizar una razonable y adecuada guarnición y protección voluntariamente provista al empleado por el empleador;
4. violación de descuido del empleado de las normas o reglamentos de seguridad de su empleador o;

5. la participación voluntaria del empleado en peleas o bromas con un compañero de trabajo por cualquier motivo, relacionado con el trabajo o de otro tipo.

Lo anterior no deberá aplicar cuando era razonable bajo la totalidad de las circunstancias para no utilizar dicho equipo, o si el empleador aprobó en el trabajo comprometido en el momento de un accidente o lesión para ser realizado sin dicho equipo.

Enfermedad coronaria y derrame cerebral

La ley no provee compensación por coronaria o enfermedad de la arteria coronaria o lesión cerebro-vascular (por ejemplo, derrame cerebral), a menos que se demuestre que el esfuerzo del trabajo que causó la lesión fue más allá de lo requerido por el trabajo habitual del empleado. Otra excepción es la lesión vascular causada por temperaturas extremas.

Previa clasificación de Incapacidad/Condición pre-existente

Compensación por cualquier incapacidad permanente puede ser reducida por la existencia de una clasificación en cualquier incapacidad pre-existente aplicable.

K.S.A. 44-501(e): una adjudicación de compensación por incapacidad parcial permanente, incapacidad de trabajo o incapacidad total permanente deberá ser reducida por la cantidad de incapacidad funcional determinada a ser preexistente. Cualquier mencionada reducción no deberá aplicar a incapacidad total temporal, ni deberá aplicar a compensación por tratamiento medico.

K.S.A. 44-501(e)(1): donde beneficios de compensación de trabajadores han sido adjudicados previamente a través de un acuerdo o una determinación judicial administrativa en Kansas, las bases del porcentaje de previo acuerdo o adjudicación deberá establecer conclusivamente la cantidad de incapacidad funcional determinada a ser preexistente. Donde beneficios de compensación de los trabajadores no han sido previamente adjudicados a través de un acuerdo o determinación judicial o administrativa en Kansas, la cantidad de incapacidad funcional preexistente deberá ser establecida por evidencia competente.

Directrices para Obtener Tratamiento Médico

¿Quién paga?

Los empleadores son responsables de todo tratamiento médico necesario para una lesión o enfermedad relacionada con el trabajo. Esto incluye:

- servicios de un médico profesional con licencia;
- cirugías, hospital y otros tratamientos médicos;
- medicamentos, médicos y quirúrgicos suministrados;
- servicios de enfermería;
- muletas y otros aparatos médicos;
- servicios de ambulancia; y
- transporte entre el domicilio del empleado y el lugar de tratamiento médico, sujeto a un mínimo de cinco millas de viaje redondo.

Si un empleador tiene seguro de compensación de trabajadores, la compañía de seguros es requerida a pagar por gastos médicos aplicables. Los empleadores no asegurados sujetos a las leyes de compensación de trabajadores siguen siendo responsables de las facturas médicas de los trabajadores cubiertos

Los empleadores tienen el derecho legal de elegir al médico del tratamiento. Si un empleado selecciona por sí mismo a un médico no autorizado o que no ha sido acordado con el empleador, el empleador es responsable solamente por los primeros 500 dólares en facturas médicas de dichos médicos seleccionados por el empleado

Exámenes Ordenados por el Empleador

Después de obtener cualquier atención médica de emergencia necesaria, el empleado deberá someterse a cualquier examen físico razonable ordenado por el empleador. El empleador también puede requerir que el em-

pleado se someta a exámenes de continuo – hasta dos veces al mes, o más seguido si es específicamente ordenado por la División de Compensación de Trabajadores. Los empleados pueden perder su derecho a beneficios que están disponibles si se niegan a someterse a dichos exámenes. Los empleados tienen derecho a conocer los resultados de cualquier examen físico ordenado por el empleador. A petición del empleado, el doctor conduciendo el examen, debe proporcionar al empleado, dentro de un plazo razonable después del examen, un informe idéntico al que envió al empleador o compañía de seguros del empleador. Los empleados tienen derecho a tener su propio médico presente, y participar en cualquier examen médico ordenado por el empleador. Si esto no se permite, o si no se proporciona una copia del reporte médico a los empleados, entonces el examen ordenado por el empleador no será admitido como evidencia relacionada con el reclamo.

Fraude y Abuso

La División de Compensación de Trabajadores y el Departamento de Seguros de Kansas tienen unidades dedicadas la investigación de actos fraudulentos o abusivos y prácticas que ocurren con respecto a la Ley de compensación de trabajadores. Generalmente pueden ser actos o conductas que se consideran fraudulentas o abusivas descritos como situaciones en que los reclamantes, empleadores o empresas fallan o se niegan a seguir las directrices de la ley de compensación de trabajadores. La ley de compensación de trabajadores aplica a lo siguiente:

- personas reclamando beneficios bajo la Ley de Compensación de Trabajadores;
- los empleadores sujetos a los requisitos de la Ley de Compensación de Trabajadores;
- planes de aseguradoras y grupos mancomunados auto-asegurados, proporcionando cobertura para lesiones relacionadas con el trabajo;
- cualquier persona, empresa, negocio o clínica de salud proporcionando tratamiento para lesiones relacionadas con el trabajo;
- abogados y otros representantes de los empleadores, empleados, aseguradores o de otras entidades involucradas en la administración de la Ley de Compensación de Trabajadores.

Si el director o el fiscal adjunto asignado a la División de Compensación de Trabajadores, tiene causa probable para creer que un acto fraudulento o abusivo o práctica que viola la Ley de Compensación de Trabajadores ha ocurrido, una copia de cualquier orden y todos los informes de investigación y cualquier evidencia en la posesión de la División de Compensación de Trabajadores que se relaciona a dicha ley deberá remitirse al fiscal del condado en el que ocurrió el acto.

Cualquier persona que cree que se ha ocurrido una violación a la ley de Compensación de Trabajadores puede notificar a la División de Compensación de Trabajadores inmediatamente y debe enviar la información relativa a la presunta violación a la División. El director deberá evaluar los hechos en torno a la supuesta violación para determinar en qué medida, si los hubiere, cuales violaciones de la Ley de Compensación de Trabajadores existe. Para obtener más información, llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe un correo electrónico a wcfraud@dol.ks.gov.

Cualquier persona que tenga una queja contra una compañía de seguros, o de otra persona/entidad regulada por Departamento de Seguros de Kansas, en relación con la tramitación de un reclamo de compensación de trabajadores, debe comunicarse con la División de lucha contra fraude en el Departamento de Seguros de Kansas. Las quejas pueden hacerse llamando a los teléfonos (800) 432-2484 o (785) 296-3071, por escrito enviando información a la División de lucha contra fraude a 420 SW 9th St, Topeka, KS 66612 o en el internet en www.ksinsurance.org.

Cobertura y Cumplimiento de Normas

La sección de Cumplimiento supervisa y asiste a los empleadores para asegurar que cumplan con dos requisitos bajo la Ley de Compensación de trabajadores:

1. para proteger los beneficios de compensación de trabajadores para empleados y
2. para presentar informes por escrito de supuestos accidentes de trabajo.

Falta de asegurar beneficios de compensación de trabajadores o de reportar accidentes puede resultar en penas monetarias contra el empleador. Falta de asegurar beneficios de compensación a los trabajadores también puede resultar en la clausura del negocio.

Todos los empleadores están obligados por ley a reportar cualquier supuesto accidente que haya ocurrido en el curso del empleo, que total o parcialmente incapacite al trabajador de trabajo o servicio por más del día, cambio de trabajo o de turno en el que ocurrió el presunto accidente. El reporte del accidente deberá presentarse con la División de Compensación de Trabajadores dentro de 28 días después de que el empleador recibe conocimiento del accidente.

Cuando el director tiene motivos para creer que un empleador ha incurrido en el conocimiento y falta intencional de asegurar el pago de compensación de Trabajadores a sus empleados, el director deberá emitir y entregar a tal empleador una declaración de los cargos y deberá conducir una audiencia de conformidad con la Ley de Procedimientos Administrativos del estado de Kansas. El empleador puede ser responsable ante el Estado por una pena civil en una cantidad igual a dos veces la prima anual o 25,000 dólares, cualquier cantidad que sea mayor

El director deberá ordenar a los empleadores de entrar bajo la ley de Compensación de Trabajadores mediante:

1. asegurar y mantener asegurado el pago de dicha compensación con una compañía de seguros autorizada para tramitar las actividades de seguro de compensación de trabajadores en el estado de Kansas;
2. mostrando al director que el empleador porta ese riesgo propio y que es conocido por estar auto-asegurado y mediante proveer prueba al director de la capacidad financiera del empleador de pagar dicha compensación por sí mismo; o
3. manteniendo una membresía en un grupo financiero de fondo común que sea cualificado El costo para proveer dicho seguro o riesgo deberá ser pagado por el empleador y no el empleado.

Para mas información llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe su correo electrónico a: wccompliance@dol.ks.gov o visite el sitio en internet www.dol.ks.gov.

Compruebe Cobertura

Usted puede comprobar si una empresa tiene cobertura de compensación de trabajadores en el internet. El sitio proporciona acceso al público a porciones de la información reportada por compañías aseguradoras privadas de compensación de trabajadores para uso del Departamento Laboral de Kansas (KDOL). La exactitud de los datos de cualquier tercer partido no puede ser garantizado por la agencia y KDOL no es responsable de la información de cobertura disponible a través de este enlace.

Para obtener ayuda adicional para verificar la cobertura de compensación de trabajadores en Kansas, llamar a Cobertura y cumplimiento de normas de la División de Compensación de Trabajadores al (785) 296-4000.

Servicios de Salud y Seguridad

La prevención de accidentes y seguridad en el lugar de trabajo es un elemento clave de la ley. Este requisito fue diseñado para reducir reclamos/pérdidas, lo que mantendría bajas las primas para los empleadores. Debido a que las tarifas se basan en las pérdidas, la prevención de accidentes de los empleados, a través de medidas elevadas de seguridad, es una de las mejores maneras en que los empleadores pueden ayudar a mantener bajas las tasas de interés.

De acuerdo con la ley, las compañías de seguros y planes de grupos financieros deben proporcionar programas de prevención de accidente cuando sea solicitado por sus asegurados. Aviso de tales programas de prevención de accidentes debe aparecer en la portada de todas las pólizas emitidas después de julio de 1993.

Programas Ofrecidos por el Departamento Laboral de Kansas

Consulta: ofrece asistencia a los empleadores del sector privado en las evaluaciones del programa de salud y seguridad. Los consultores ofrecen asesoría en el reconocimiento, evaluación y control de riesgos laborales. Asistencia con la iniciación y el desarrollo del programa está disponible. Entrenamiento, formal e informal, es realizado en todas las áreas de salud y seguridad. Todos los servicios son sin costo al cliente.

Cumplimiento del Sector Público: supervisa al sector público – ciudades, condados, agencias estatales y distritos escolares – mediante la realización de auditorías de cumplimiento bajo el artículo K.S.A. 44-636 o K.S.A. 44-575(f). Se identifican los riesgos laborales y se evalúan los elementos del programa. Los riesgos deben ser

disminuidos dentro de 60 días. También se realizan investigaciones de quejas de empleados, accidentes leves y fatalidades.

Prevención de Accidentes: evalúa las compañías de seguros y planes de auto-seguro de grupo financiero para garantizar que están ofreciendo y proporcionando servicios de seguridad y salud sin costo para sus asegurados, como es requerido por la ley. La calidad y cantidad de estos servicios son evaluadas por consultores capacitados mediante revisar directamente los registros de la compañía de seguros y ponerse en contacto con aquellos que han solicitado y han recibido los servicios.

Conferencia de Salud y Seguridad: la Conferencia anual de Salud y Seguridad de Kansas reúne a los representantes del sector industrial, académico, proveedor y del Gobierno La Conferencia se lleva a cabo sin la ayuda de otros y trata de abordar las cuestiones relevantes de seguridad en una variedad de talleres y presentaciones.

Asistencia para salud y seguridad en el lugar de empleo está disponible llamando al (785) 296-4386 o envío de correo electrónico a indsafetyhealth@dol.ks.gov. Usted también puede encontrar información en el internet bajo Seguridad Laboral visitando www.dol.ks.gov.

Servicios de la Sección Ombudsman

La División de Compensación de trabajadores de Kansas estableció una Sección de Asesoramiento al Reclamante en el año de 1978. En 1993 la Legislatura siguió una tendencia nacional y, por ley, crearon el programa Ombudsman. La legislación de reforma de la compensación de los trabajadores en 1993 se ordenó una definición más amplia para la Sección de Consejeros para Reclamantes, facilitando el llevar un papel más activo para ayudar a todos los participantes a entender sus derechos y sus responsabilidades bajo la ley de Compensación para Trabajadores.

La División emplea personal de tiempo completo que se especializan en ayudar a los trabajadores lesionados, los empleadores y profesionales en seguros con información de reclamos y problemas derivados de accidentes de trabajo y enfermedades. El ombudsman actúa de manera imparcial y está disponible para proporcionar a los participantes información acerca de asuntos actualizados dentro del sistema de compensación de trabajadores. Por ejemplo, el ombudsman tiene información actualizada sobre cambios legislativos o modificaciones debido a decisiones tomadas por la Junta de compensación de trabajadores o del sistema legal. La sección de ombudsman también puede ayudar con temas específicos o reclamos actuales de compensación de trabajadores.

Ayudando a los trabajadores lesionados con:

- Proporcionando información general
- Obteniendo tratamiento médico
- Beneficios no pagados o no pagados oportunamente
- Beneficios médicos no pagados
- Cálculos de beneficios
- Notificación oportuna del empleador
- Procedimientos para la solicitud de una audiencia
- Obtención de beneficios de los sobrevivientes
- Resolución informal de disputas
- Asistencia de mediación
- Interpretación para los trabajadores de habla hispana

Ayudar a los empleadores/compañías de seguros:

- Proporcionando información general
- Exhibir el aviso de Compensación de Trabajadores (K-WC 40 y 40-A)
- Proporcionando información requerida a los trabajadores lesionados (K-WC 27 o 27-A/K-WC 270 o 270-A)
- Presentación oportuna de los reportes de accidentes
- Pago oportuno y adecuado de los servicios médicos

- Información de elecciones
- Asistencia con requisitos del beneficio por fallecimiento
- Resolución de disputa informal
- Asistencia con los trabajadores de habla hispana
- Capacitación del personal de empleador en cuestiones de compensación de trabajadores
- Visitas de asistencia práctica a los sitios de trabajo

Asistencia de un Ombudsman está disponible ya sea en persona o llamando al (785) 296-4000 o al (800) 332-0353. Usted también puede enviar un correo electrónico a wc@dol.ks.gov. Además, los formularios están disponibles para su descarga en www.dol.ks.gov.

Unidad de servicios al empleador Para asistencia técnica y presentaciones y capacitación para empleadores, llame al (785) 296-4000 o (800) 332-0353, o escriba al correo electrónico wcemployerservices@dol.ks.gov.

Mediación

La mediación fue legislativamente creada en 1996 ([K.S.A. 44- 5.117](#)) y puede ser utilizada en cualquier momento durante el proceso de compensación de trabajadores. El estatuto fue enmendado en 1998 para permitir la mediación por video conferencias. La mediación no es obligatoria o un requisito previo para una audiencia y puede ser utilizado en cualquier tiempo durante el proceso de compensación del trabajador. Los asuntos que se pueden mediar no se limitan a cuestiones de tratamiento médico o beneficios de incapacidad total temporal.

¿Qué es la mediación?

La mediación es un medio de resolver los conflictos en un informal y no contencioso ambiente. El las partes en una controversia utilizan un tercero neutral para facilitar la discussion. El mediador no tiene ninguna autoridad haciendo decisiones o interés en el resultado del conflicto. El trabajo del mediador es ayudar a las partes involucradas para identificar las cuestiones en disputa y el establecimiento de objetivos communes. La clave de la mediación es que permite las partes involucradas a trabajar a través de su disputa y crear sus propios acuerdos.

¿Quiénes son los mediadores?

Los mediadores son empleados de la División de Compensación de Trabajadores que han recibido especial capacitación en el proceso de mediación. Los mediadores utilizados por la División de compensación para trabajadores cumplen o superan los requisitos establecidos por [K.S.A. 5-501](#) y enmiendas al mismo y cualquier regla pertinente de la Corte Suprema de Kansas en conformidad con el artículo [K.S.A. 5-510](#) y enmiendas. Los mediadores reciben capacitación en técnicas de resolución de conflictos, neutralidad, preparación de acuerdos, ética, desempeño como mediador, habilidades de comunicación, evaluación de casos y las leyes que rigen la mediación.

Representación y asistencia

Cualquiera de los participantes podrá estar representado por un abogado en esta conferencia de mediación o podrá solicitar asistencia de la Sección Ombudsman/Consejeros de Reclamos. La ausencia de un abogado durante el proceso no significa que representación legal no puede obtenerse posteriormente si la disputa no se resuelve en este contexto informal.

Para obtener información adicional o para programar una conferencia de mediación, llame al (785) 296-4000 o (800) 332-0353 Escribir a la Sección de Mediación, Departamento Laboral de Kansas, División de Compensación de Trabajadores, 401 SW Topeka Boulevard, Topeka, KS 66603-3182 Puede enviar correo electrónico a wcmediation@dol.ks.gov.

Servicios médicos

La función principal de la sección de Servicios Médicos es la administración de la programación de honorarios medicos. El programa de honorarios es actualizado y revisado anualmente para promover la contención del costo de salud, y todavía asegurar la disponibilidad de tratamiento necesario y cuidado para los empleados lesionados.

La sección de Servicios Médicos está disponible para actuar como un enlace entre los proveedores de atención médica, empleadores, empleados, aseguradoras, grupos financieros con fondo común o empresas auto-aseguradas. Además, la sección conduce audiencias informales para ayudar en la resolución de reclamos médicos en disputa y pagos relacionados que envuelven a proveedores de atención médica.

Para obtener ayuda para resolver los problemas relacionados con interpretación de programación de tarifa, disputas de pago, etc., contacte la sección de servicios médicos al (785) 296-4000 o fax (785) 296-0025.

Rehabilitación profesional

Rehabilitación profesional podrá facilitarse a opción del empleador o de la aseguradora del empleador. La experiencia general ha demostrado que cuanto mayor sea el lapso de tiempo que el empleado esté fuera del trabajo en recuperación de una lesión, mayor será la probabilidad de que un empleado necesitará rehabilitación vocacional para reanudar trabajo adecuado a una remuneración comparable.

Si el empleador o la compañía de seguros no eligen proporcionar rehabilitación profesional, el empleado puede pedir al administrador de rehabilitación una referencia con un proveedor de dichos servicios a expensas del empleado. El empleado también puede solicitar una referencia a la División de Servicios de Rehabilitación en el Departamento de Servicios de Rehabilitación Social de Kansas.

Para obtener ayuda con la rehabilitación profesional, póngase en contacto con la oficina del administrador de rehabilitación en la División de Compensación de Trabajadores (800) 332-0353, (785) 296-4000 o envíe un correo electrónico a wcrehab@dol.ks.gov.

Departamento Laboral de Kansas División de Compensación de Trabajadores

Departamento de Seguros de Kansas

IMPORTANT NOTICE TO NEVADA POLICYHOLDERS

Dear Policyholder:

Nevada law requires that you complete form C-3 within six (6) days from the receipt of the report of initial treatment (form C-4). Form C-3 should be forwarded to our Claim Department. Failure to timely complete form C-3 may result in administrative fines to you in the amount of \$1,000 per violation.

For additional information please contact us at 1-800-832-7839.

"For your convenience, the following is the applicable statutory language."

AC616A.480 Use, alteration, printing and distribution of certain posters and forms.

1. The following posters and forms or data must be used by an insurer, employer, injured employee, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation:

(d) C-3, Employer's Report of Industrial Injury or Occupational Disease. A copy of the form must be delivered to or the form must be filed by electronic transmission with the insurer or third-party administrator. The form signed by the employer must be retained by the employer. A copy of the form must be delivered to the injured employee. If the employer files the form by electronic transmission, the employer must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the employer that is:

- i. Unique to the employer;
- ii. Capable of verification; and
- iii. Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original report of industrial injury or occupational disease for 3 years. If the employer moves from or ceases operation in this state, the employer shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of operation.

3. The forms listed in this section must be accurately completed, including, without limitation, a signature and a date if required by the form. An insurer or employer may designate a third-party administrator as an agent to sign any form listed in this section.

NRS 616C.045 Report of industrial injury or occupational disease: Duty of employer to file; electronic filing; form and contents; penalty.

1. Except as otherwise provided in NRS 616B.727, within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, an employer shall complete and file with his insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

- (a) Be on a form prescribed by the administrator;
- (b) Be signed by the employer or his designee;
- (c) Contain specific answers to all questions required by the regulations of the administrator; and

- (d)** Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor indicates that the injured employee is expected to be off work for 5 days or more.
- 3. An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or his designee. The form must be mailed within 7 days after receiving such a request.
- 4. The administrator shall impose an administrative fine of not more than \$1,000 on an employer for each violation of this section.

NEW MEXICO

Dear Policyholder:

Enclosed is your New Mexico Workers' Compensation Posting Notice which must be displayed conspicuously where notice to employees and applicants for employment are customarily posted.

You as an employer are also responsible for making blank "Notice of Accident" forms available to your employees wherever this notice is posted. You should contact The Workers' Compensation Administration (WCA) for a supply of the current "Notice of Accident" forms to be used with your Posting Notice.

NEW MEXICO

Dear Policyholder:

Enclosed is your New Mexico Workers' Compensation Posting Notice which must be displayed conspicuously where notice to employees and applicants for employment are customarily posted.

You as an employer are also responsible for making blank "Notice of Accident" forms available to your employees wherever this notice is posted. You should contact The Workers' Compensation Administration (WCA) for a supply of the current "Notice of Accident" forms to be used with your Posting Notice.

NEW MEXICO

Dear Policyholder:

Enclosed is your New Mexico Workers' Compensation Posting Notice which must be displayed conspicuously where notice to employees and applicants for employment are customarily posted.

You as an employer are also responsible for making blank "Notice of Accident" forms available to your employees wherever this notice is posted. You should contact The Workers' Compensation Administration (WCA) for a supply of the current "Notice of Accident" forms to be used with your Posting Notice.

POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2007, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act that is certified by the Secretary of the Treasury—in concurrence with the Secretary of State, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a \$100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds \$100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed \$100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is _____ *****, and does not include any charges for the portion of losses covered by the United States government under the Act.

***** "SEE INFORMATION PAGE SCHEDULE FOR PREMIUM CHARGE"



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

POLICY NUMBER: (TRJUB-4246B09-2-14)

NOTICE OF ELECTION TO ACCEPT THE OREGON EMPLOYER PAID MEDICAL CLAIMS

This notice applies only to medical benefits provided by Part One (Workers Compensation Insurance) because Oregon is shown in Item 3.A. of the Information Page.

1. Oregon law allows you to reimburse us up to a defined amount for medical services we have paid for any accepted nondisabling claim if you so choose. This defined amount is determined by the Workers' Compensation Division, Department of Consumer and Business Services, and is subject to an annual adjustment ("maximum reimbursable amount"), published annually by the Oregon Department of Consumer and Business Services in Bulletin No. 345.
2. The current maximum reimbursable amount is \$1,800 per claim, but you can choose an amount lower than the maximum.
3. A nondisabling claim is defined as one where the injured person does not receive any lost time benefits.
4. If you choose to reimburse us for these medical payments made under this policy, you must still report the injury to us in the same manner that other injuries are reported but the amount paid by you will not be used in your subsequent experience rating modifications or otherwise be used to make charges against you. **Note that this reimbursement has no advantage unless your premium at least meets the experience rating threshold.**
5. If you choose to reimburse us for these medical payments made under this policy: (1) Complete the form below within thirty days of receipt of this notice; (2) Retain a copy for your records; and (3) Send a copy to us and your producer to inform him/her of your intention. An endorsement will then be attached to your policy to reflect your election.
6. Your election to participate in this program means that you agree to receive a monthly bill for the payments we made on your accepted nondisabling claims which are eligible for reimbursement. Please return a copy of your billing statement and payment within thirty days of receipt of the bill. Your failure to reimburse us will be deemed notice to us that you have decided to not participate in this program for that billing period. Notwithstanding, you will continue to receive monthly billing on any claim eligible for reimbursement for up to twenty-seven months of the inception of the policy period.
7. The bill may use the term "deductible" in reference to the Oregon Employer Paid Medical Claims program billing.
8. **If you decide that you do not want to participate in the Oregon Employer Paid Medical Claims program, you may simply disregard this notice.** You are deemed to have chosen not to participate in this program if you fail to complete this notice and return it within thirty days of your receipt. Your policy will continue in force as issued. You may send this form in any time during the policy period if you change your mind going forward.



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

POLICY NUMBER: (TRJUB-4246B09-2-14)

9. A new notice of election to accept the Oregon Employer Paid Medical Claims program will be provided to you on an annual basis for applicable renewal policies.

Yes, I wish to reimburse medical payments made on nondisabling claims as indicated below. Per claim reimbursement amount (choose one):

\$200; \$300; \$400; \$500; \$600; \$700; \$800; \$900; \$1000;
 \$1100; \$1200; \$1300; \$1400; \$1500; \$1600; \$1700; \$1800

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

STATE OF OREGON IMPORTANT LOSS CONTROL INFORMATION

Your Rights And Responsibilities:

As an employer you are required by the Oregon Safe Employment Act to provide a safe and healthful workplace. Refer to the enclosed Safety Services notice for available services offered to you.

Oregon OSHA Division 1 General Administrative Rules require that you, the employer, distribute this notice and the enclosed Safety Services notice to each of your fixed places of employment within the State of Oregon. We suggest you direct the information to the person assigned the responsibility for accident prevention.

If we fail to respond to a request for loss prevention services or otherwise fail to provide services as offered or required, you have the right to make a complaint to the OR-OSHA Division.

Notification of Services

The Oregon Administrative Rules require each insurer to inform insured employers of the loss prevention services that are available. The Rules also require that insured employers are notified of the following information.

Loss prevention services and personnel providing the services must meet the needs of the particular place of employment, special industry, or process, and shall include at least the following:

- * **Evaluation of the employers' loss prevention needs;**
- * **Assistance in evaluating records that may be pertinent to the firm's illness and injury experience;**
- * **An explanation to the employer of the Oregon Safe Employment Act and rules that apply to the particular place of employment;**
- * **Provision of partial or complete on-site health and safety surveys, which identify all reasonably discoverable occupational safety and health hazards within the scope of the survey scheduled;**
- * **Assistance with industrial hygiene and safety evaluations to detect physical and chemical hazards of the workplace, and implementation of engineering or administrative controls;**
- * **Assistance with evaluating, obtaining, and maintaining personnel protective equipment;**
- * **Evaluation of work practices, workplace design, and assistance with job site modifications;**
- * **Assistance in evaluating and improving an employers' safety management practices;**
- * **Assistance in identifying health and safety training needs and available resources; and**
- * **An offer to provide follow-up services.**

Our Loss Prevention & Engineering Division offers these services – and more – upon request, when the nature of the operations and hazards warrant these services. See the enclosed Safety Services notice for the Loss Prevention & Engineering Office nearest you.

Dear Policyholder:

Due to a recent change in Oregon legislation we are providing you with a written description of work activities associated with each authorized classification used on your policy. These code descriptions are attached.

If you feel your operations are not adequately described by this information please contact your agent.

IMPORTANT NOTICE TO OREGON POLICYHOLDERS

OREGON INSURANCE GUARANTY ASSOCIATION SURCHARGE

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

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

ATTENTION

The following Posting Notices must be displayed in a prominent location in the workplace.

Please distribute these notices to the appropriate workplace locations.

In the event that additional copies are desired, please contact your agent and request the number of copies of the particular notices that you may need.

Posting notices for the states of MO, NM and TX (Spanish Version) are provided in two separate forms which need to be connected to create one large notice to be posted.

Please contact us at wcppn@travelers.com for assistance in completing the healthcare provider information on posting notices in PA, GA, TN, and VA.

TO BE POSTED BY EMPLOYER

POLICY NUMBER (TRJUB-4246B09-2-14)

ISSUED TO: **GARDEN FRESH RESTAURANT CORP**

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: **THE TRAVELERS INSURANCE COMPANIES**

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA (TRJUB-4246B09-2-14)

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACIÓN PARA LOS TRABAJADORES DE ARIZONA

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RE: LEY DE COMPENSACIÓN PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Título 23, Capítulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensación por medio de: **THE TRAVELERS INSURANCE COMPANIES**

Además, a todos los empleados se les notifica por este medio que en caso de que específicamente ellos no rechacen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

* * * * *

**KEEP POSTED IN A CONSPICUOUS PLACE.
COLOQUESE EN LUGAR VISIBLE.**

TO BE POSTED BY EMPLOYER

POLICY NUMBER (TRJUB-4246B09-2-14)

ISSUED TO: **GARDEN FRESH RESTAURANT CORP**

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: **THE TRAVELERS INSURANCE COMPANIES**

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

* * * * *

PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA (TRJUB-4246B09-2-14)

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EMPLOYEE SAFETY AND HEALTH PROTECTION

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As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795



Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational safety and Health plan may do so at the following address:

U.S. Department of Labor - OSHA
3221 N.16th St., Suite 100
Phoenix, AZ 85016
Telephone: 1-800-475-4020

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The Arizona Occupational Safety and Health Act of 1972 (Act), provides safety and health protection for employees in Arizona. The Act requires each employer to furnish his employees with a place of employment free from recognized hazards that might cause serious injury or death. The Act further requires that employers and employees comply with all workplace safety and health standards, rules and regulations promulgated by the Industrial Commission. The Arizona Division of Occupational Safety and Health (ADOSH), a division of the Industrial Commission of Arizona, administers and enforces the requirements of the Act.

As an employee, you have the following rights:

You have the right to notify your employer or ADOSH about workplace hazards. You may ask ADOSH to keep your name confidential.

You have the right to request that ADOSH conduct an inspection if you believe there are unsafe and/or unhealthful conditions in your workplace. You or your representative may participate in the inspection.

If you believe you have been discriminated against for making safety and health complaints, or for exercising your rights under the Act, you have a right to file a complaint with ADOSH within 30 days of the discriminatory action. You are also afforded protection from discrimination under the Federal Occupational Safety and Health Act and may file a complaint with the U.S. Secretary of Labor within 30 days of the discriminatory action.

You have the right to see any citations that have been issued to your employer. Your employer must post the citations at or near the location of the alleged violation.

You have the right to protest the time frame given for correction of any violation.

You have the right to obtain copies of your medical records or records of your exposure to toxic and harmful substances or conditions.

Your employer must post this notice in your workplace.

The Industrial Commission and ADOSH do not cover employers of household domestic labor, those in maritime activities (covered by OSHA), those in atomic energy activities (covered by the Atomic Energy Commission) and those in mining activities (covered by the Arizona Mine Inspector's office). To file a complaint, report an emergency or seek advice and assistance from ADOSH, contact the nearest ADOSH office:

Phoenix:
800 West Washington
Phoenix AZ. 85007
602-542-5795



Tucson:
2675 East Broadway
Tucson, AZ. 85716
520-628-5478

Industrial Commission web site: www.ica.state.az.us

Note: Persons wishing to register a complaint alleging inadequacy in the administration of the Arizona Occupational safety and Health plan may do so at the following address:

U.S. Department of Labor - OSHA
3221 N.16th St., Suite 100
Phoenix, AZ 85016
Telephone: 1-800-475-4020

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PROTECCION DE SEGURIDAD Y SANIDAD PARA EL EMPLEADO

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Como empleado, Ud. tiene los derechos siguientes:

Tiene el derecho de notificar a su patron o a ADOSH sobre peligros en su lugar de trabajo. Puede pedir a ADOSH que mantenga su nombre confidencialmente.

Tiene el derecho de solicitar una inspección por parte de ADOSH si cree que existen condiciones peligrosas o poco saludables en su lugar de trabajo. Usted o su representante puede participar en la inspección.

Si cree que su patron lo ha discriminado por presentar reclamos de seguridad y sanidad o por ejercer sus derechos bajo el Acta, puede presentar una queja a ADOSH durante un plazo de 30 dias después de la acción de discriminación. También tiene protección de discriminación bajo el acta federal de seguridad y sanidad ocupacional y puede archivar una queja con el Secretario de Labor de los Estados Unidos dentro de 30 dias después de la discriminación alegada.

Tiene el derecho de ver las citaciones enviadas a su empleador. Su empleador debe colocar las citaciones en un lugar visible en el sitio de la supuesta infracción o cerca de el.

Tiene el derecho de protestar el tiempo dado para correjir una violación.

Tiene el derecho de recibir copias de su historial médico o de los registros de su exposición a sustancias o condiciones tóxicas y peligrosas.

Su empleador debe colocar este aviso en su lugar de trabajo.

La ley de seguridad y sanidad en el trabajo no aplica a aquellos patrones que emplean a servicio doméstico, a patrones de actividades marítimas (protegidos bajo OSHA), a patrones en actividades de energía atómica (protegidos bajo la Comisión de Energía Atómica), o a patrones en actividades mineras (protegidos por la Oficina del Inspector de Minas del Estado de Arizona). Para registrar una queja, reportar una emergencia o pedir asistencia de ADOSH, póngase en contacto con la oficina más cercana:

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602-542-5795



Tucson:
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Tucson, AZ. 85716
520-628-5478

Industrial Commission web site: www.ica.state.az.us

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Teléfono: 1-800-475-4020

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WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.
2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.
3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.
4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN EVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

**KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES**

THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

WORK EXPOSURE TO BODILY FLUIDS

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2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a *prima facie* claim.
3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.
4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN EVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

**KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES**

THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

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THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Sindrome de la Inmunodeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Sindrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluir el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirurgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o use ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA o Hepatitis C si reUnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirurgico(s) o cualquier otro fluido que contenga sangre. Incluidos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos medicos de emergencia, paramédicos y-agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patron por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patron o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para VIH O HEPATITIS C por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** despues de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL DE
ARIZONA PARA USO DE LAS ASEGURADORAS

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EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

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4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLEADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL DE ARIZONA PARA USO DE LAS ASEGURADORAS

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Sindrome de la Inmunodeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Sindrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluir el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirurgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION.** Las reclamaciones no pueden resultar de actividad sexual o use ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA o Hepatitis C si reUnen los requisitos siguientes:

1. El curso regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirurgico(s) o cualquier otro fluido que contenga sangre. Incluidos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos medicos de emergencia, paramédicos y-agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patron por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patron o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante el empleado va a que le saquen sangre, y **NO MAS DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para VIH O HEPATITIS C por medio de análisis de anticuerpos y el análisis resulta negativo.

4. **NO MAS DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VIH, o **NO MAS DE SIETE (7) MESES** despues de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACION PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISION INDUSTRIAL DE
ARIZONA PARA USO DE LAS ASEGURADORAS

WORK EXPOSURE TO METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;
2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;
3. A diagnosis is made within the following time-frames:
 - a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;
 - b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and
 - c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

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Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;
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Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

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ISSUED TO: GARDEN FRESH RESTAURANT CORP



STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

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

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Phone **1-800-832-7839**

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Policy Expiration Date **04-01-15**

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ISSUED TO: GARDEN FRESH RESTAURANT CORP



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ISSUED TO: GARDEN FRESH RESTAURANT CORP



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Phone **1-800-832-7839**

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Policy Expiration Date **04-01-15**

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. There is a limit on some medical services.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if your injury causes a permanent disability.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher payable to a state approved school if your injury arises on or after 1/1/04 and results in a permanent disability that prevents you from returning to work within 60 days after TD ends, and your employer does not offer you modified or alternative work.
- **Death Benefits:** Paid to dependents of a worker who dies from a work-related injury or illness.

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

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer shall authorize the provision of all treatment, consistent with the applicable treating guidelines, for your alleged injury and shall be liable for up to ten thousand dollars (\$10,000) in treatment until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness. If you predesignated by naming your personal physician or medical group before injury (see above), you may see him or her for treatment in certain circumstances. Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. You may be able to switch to a doctor of your choice after 30 days. Different rules apply if your employer offers a Health Care Organization (HCO) or has a Medical Provider Network (MPN). You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
4. **Medical Provider Networks.** Your employer may be using a MPN, which is a selected network of health care providers to provide treatment to workers injured on the job. If your employer is using a MPN, a MPN notice should be posted next to this poster to explain how to use the MPN. You can request a copy of this notice by calling the MPN number below. **If you have predesignated a personal physician prior to your work injury, then you may receive treatment from your predesignated doctor.** If you have not predesignated and your employer is using a MPN, you are free to choose an appropriate provider from the MPN list after the first medical visit directed by your employer. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

Current MPN's toll free number: **(800) 287-9682** MPN website: WWW.MYWCINFO.COM

MPN Effective Date _____ Current MPN's address: **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator _____

Phone **1-800-832-7839**

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

Policy Expiration Date **04-01-15**

If the workers' compensation policy has expired, contact a Labor Commissioner at the Division of Labor Standards Enforcement (DLSE).

You can also get free information from a State Division of Workers' Compensation Information & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about DWC and DLSE online: www.dwc.ca.gov or www.dir.ca.gov/dlse.

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

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



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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



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División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____
Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
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 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

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

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- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN **11/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN **11/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **12/31/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

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 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesioné y su médico debe estar de acuerdo de atenderle la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN **P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MRN: **12/31/2024** Dirección de la MRN vigente: **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Asegurador del Seguro de Compensación de trabajo
Fecha de Vencimiento de la Póliza: 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement, DLSE).

de las Normas Laborales (Division of Labor Standards Enforcement- DLSE). Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7470. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/01/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____
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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza **04-01-15**

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

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 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/2023** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofreca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Asegurador del Seguro de Compensación de trabajadores
Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
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3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Beneficios. Los beneficios de compensación de trabajadores incluyen:

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 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **12/31/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/01/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
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 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza **04-01-15**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

Fecha de vigencia de la MPN _____ Dirección de la MPN Vigente _____

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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
 - **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
 - **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrezca a usted un trabajo modificado o alternativo.
 - **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlo para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Número gratuito de la MPN vigente: (800) 287-9682 Página web de la MPN: WWW.MYWCFINFO.COM

Fecha de vigencia de la MPN **10/2018** Dirección de la MPN vigente **P.O. BOX 6510 DIAMOND BAR, CA 91765**

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesioné y su médico debe estar de acuerdo de atenderle la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

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 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
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Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

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 - **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
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Fecha de vigencia de la MPN: **Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765**

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Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Si Usted se Lastima:

- 1. Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
 - 2. Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
 - 3. Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarlos para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
 - 4. Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: **(800) 287-9682** Página web de la MPN: WWW.MYWCINFO.COM

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrator de Recaudación TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza **04-01-15**

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito (800) 736-7401. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

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Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

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Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

Si la póliza de compensación de trabajadores se ha vencido, comuníquese con el Comisionado Laboral, en la *División para el Cumplimiento de las Normas Laborales* (Division of Labor Standards Enforcement- DLSE).

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en _____ o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre de la DWC y DLSE en el Internet en: www.dwc.ca.gov o www.dir.ca.gov/dlse.

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

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



ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

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Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías y medicinas que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay un límite para ciertos servicios médicos.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si su lesión le causa una incapacidad permanente.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible pagadero a una escuela aprobada por el estado si su lesión surge en o después del 1/1/04, y le ocasiona una incapacidad permanente que le impida regresar al trabajo dentro de 60 días después de que los pagos por TD terminen y su empleador no le ofrece a usted un trabajo modificado o alternativo.
- **Beneficios por Muerte:** Pagados a los dependientes de un(a) trabajador(a) que muere a causa de una lesión o enfermedad relacionada con el trabajo.

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

Si Usted se Lastima:

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2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador autorizará todo tratamiento médico de acuerdo con las pautas de tratamiento aplicables a su presunta lesión y será responsable por diez mil dólares (\$10,000) en tratamiento hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad. Si usted designó previamente a su médico personal o grupo médico antes lesionarse (vea uno de los párrafos anteriores), en ciertas circunstancias, usted puede consultarle para el tratamiento. De otra forma, su empleador tiene el derecho de seleccionar al médico que le atenderá durante los primeros 30 días. Es posible que usted pueda cambiar a un médico de su preferencia después de 30 días. Hay reglas diferentes que se aplican cuando su empleador ofrece una Organización de Cuidado Médico (HCO) o si tiene una Red de Proveedores Médicos (MPN). Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es una red de proveedores de asistencia médica seleccionados para dar tratamiento a los trabajadores lesionados en el trabajo. Si su empleador usa una MPN, una notificación de la MPN debe estar al lado de este cartel para explicar como usar la MPN. Usted puede pedir una copia de esta notificación hablando al número de la MPN debajo descrito. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted no ha hecho una designación previa y su empleador está usando una MPN, usted puede escoger un proveedor apropiado de la lista de la MPN después de la primera visita médica dirigida por su empleador. Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información del contacto de la MPN :

Número gratuito de la MPN vigente: (800) 287-9682

Página web de la MPN: WWW.MYWCINFO.COM

Fecha de vigencia de la MPN

Dirección de la MPN vigente P.O. BOX 6510 DIAMOND BAR, CA 91765

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

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

Administrador **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
de Reclamos

Teléfono 1-800-832-7839

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

Fecha de Vencimiento de la Póliza 04-01-15

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ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

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COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

THE TRAVELERS INSURANCE COMPANIES

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

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

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

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

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303.318.8700, or visit our website at: www.coworkforce.com/dwc/.

**COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH Street, Suite 400, Denver, CO 80202-3660**

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\$25,000 ANTI-FRAUD REWARD PROGRAM

Rewards of up to \$25,000 may be paid to persons providing information to the Dept of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the Department at 1-800-378-0445.

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.



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State Board of Workers' Compensation

270 Peachtree Street, N.W.

Atlanta, Georgia 30303-1299

404-656-3818

or 1-800-533-0682

<http://www.sbcc.georgia.gov>

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

name/address/phone

(Additional doctors may be added on a separate sheet)

The insurance company providing coverage for this business
under the Workers' Compensation Law is:

THE TRAVELERS INSURANCE COMPANIES

Name

CALLER SERVICE #1818

ALPHARETTA, GA 30023-1818

address

1-800-832-7839

phone

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

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WC-P1 (7/2006)

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WC-P1 (7/2006)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$525 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$525 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3818.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$525 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$350 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$350 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$525 per week. A widowed spouse with no children will be paid a maximum of \$150,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <http://www.sbwgc.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777.

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3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
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11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

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JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia médica temporal de cualquier otro médico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagará la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en número considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$525 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$525 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted esté incapacitado. Pero no más de 400 semanas si no está trabajando y se determina que usted está capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$350 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$350 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$525 por semana. Una esposa viuda sin niños se le pagará un máximo de \$150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente coabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su médico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenía cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del último tratamiento médico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algun pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento médico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueron causados por droga o alcohol. Si la presunción no se sobreponen por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

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CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA \$10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

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5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compa a de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su ultimo pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algun pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueron causados por droga o alcohol. Si la presunción no se sobreponde por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

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JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

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Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia médica temporal de cualquier otro médico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagará la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en número considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$525 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$525 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted esté incapacitado. Pero no más de 400 semanas si no está trabajando y se determina que usted está capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$350 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$350 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$525 por semana. Una esposa viuda sin niños se le pagará un máximo de \$150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente coabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/empleador de cambios de dirección o nuevo matrimonio.
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3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su médico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenía cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del último tratamiento médico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algun pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento médico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueron causados por droga o alcohol. Si la presunción no se sobreponen por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: <http://www.sbcc.georgia.gov>
CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA \$10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia médica temporal de cualquier otro médico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en número considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$525 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$525 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted esté incapacitado. Pero no más de 400 semanas si no está trabajando y se determina que usted está capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$350 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$350 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$525 por semana. Una esposa viuda sin niños se le pagara un máximo de \$150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente coabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compa a de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbwcc.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compa a de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su ultimo pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algun pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueron causados por droga o alcohol. Si la presunción no se sobreponde por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

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JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

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3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagará la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en número considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$525 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-3818.
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7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$350 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$525 por semana. Una esposa viuda sin niños se le pagará un máximo de \$150,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente coabite con una persona del sexo opuesto.
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4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su médico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenía cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del último tratamiento médico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algun pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento médico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueron causados por droga o alcohol. Si la presunción no se sobreponen por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
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CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA \$10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

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

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

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

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

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

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

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

Junta Estatal de Compensación de Trabajadores

270 Peachtree Street, N.W.

Atlanta, Georgia 30303-1299

404-656-3818

o 1-800-533-0682

<http://www.sbwc.georgia.gov>

nombre /dirección /teléfono

(Médicos adicionales pueden ser agregados en una hoja separada.)

La compañía de seguro que provee cobertura para esta empresa bajo la
ley de Compensación de Trabajadores es:

THE TRAVELERS INSURANCE COMPANIES

Nombre

CALLER SERVICE #1818

ALPHARETTA, GA 30023-1818

dirección

1-800-832-7839

teléfono

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

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

WC-P1 (7/2006)

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

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

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

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

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

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

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(Médicos adicionales pueden ser agregados en una hoja separada.)

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dirección

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teléfono

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

WC-P1 (7/2006)

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Nombre

CALLER SERVICE #1818

ALPHARETTA, GA 30023-1818

dirección

1-800-832-7839

teléfono

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WC-P1 (7/2006)



WORKERS' COMPENSATION

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

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

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

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

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

- 4. KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

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

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

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

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

Party handling workers' compensation claims TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA			
Business address	P.O. BOX 3205 NAPERVILLE, IL 60566-7205		
Business phone	(800) 832-7839		
Effective date	04-01-14	Termination date	04-01-15
Policy number	(TRJUB-4246B09-2-14)	Employer's FEIN	330028786



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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:

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

Party handling workers' compensation claims TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA			
Business address	P.O. BOX 3205 NAPERVILLE, IL 60566-7205		
Business phone	(800) 832-7839		
Effective date	04-01-14	Termination date	04-01-15
Policy number	(TRJUB-4246B09-2-14)	Employer's FEIN	330028786



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.

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COMPENSACION A LOS TRABAJADORES

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- 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, dirección, 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.

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- 4. MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

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

Nombre: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Dirección de la Compañía:	P.O. BOX 3205 NAPERVILLE, IL 60566-7205		
Teléfono de la Compañía:	(800) 832-7839		
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Fecha efectiva:	04-01-14	Fecha de terminación:	04-01-15
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GARDEN FRESH RESTAURANT CORP

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

Workers Compensation Rights and Responsibilities

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

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

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

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

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

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

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

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

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

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

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

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

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

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

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

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

THE TRAVELERS INSURANCE COMPANIES

Employer's Insurance Carrier (Compañía Aseguradora del Empleador)

() (800) 832-7839

Telephone (Teléfono de la Aseguradora)

**PO BOX 2928
OVERLAND PARK, KS 66201-1328**

Address (Dirección de la Aseguradora)

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

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

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

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

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

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

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

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

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

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

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

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

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

THE TRAVELERS INSURANCE COMPANIES

Employer's Insurance Carrier (Compañía Aseguradora del Empleador)

() (800) 832-7839

Telephone (Teléfono de la Aseguradora)

**PO BOX 2928
OVERLAND PARK, KS 66201-1328**

Address (Dirección de la Aseguradora)

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

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

Web site: www.dol.ks.gov/workcomp/default.aspx
E-mail: wc@dol.ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 4-13)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer.

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The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of \$500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.
2. Employers must provide for the payment of workers compensation claims without any charge to employees.
3. Employers must post the Workers Compensation Notice prepared by the Director.
4. Employers must pay compensation benefits, regardless of insurance coverage.
5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

PO BOX 2928

Address OVERLAND PARK, KS 66201-1328

Contact Person _____

Phone (_____) (800) 832-7839

E-mail _____

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YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

PO BOX 2928

Address OVERLAND PARK, KS 66201-1328

Contact Person _____

Phone (_____) (800) 832-7839

E-mail _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 4-13)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 20 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, 20 días a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 10 días después del último día de trabajo para dicho empleador.

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(2) SIGA LAS INSTUCCIONES DE SU EMPLEADOR para conseguir ayuda médica y siga las instrucciones del doctor.

(3) BENEFICIOS MÉDICOS: El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) BENEFICIOS SEMANALES: **Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. El empleador debe reportar cada accidente de los trabajadores a la División of Compensación de Trabajadores dentro de 28 días de la fecha del accidente, o de la fecha en que el empleador se haya dado cuenta del accidente, cuando el trabajador esté completa o parcialmente incapacitado por lo que resta del día o del turno.
2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

PO BOX 2928

Dirección OVERLAND PARK, KS 66201-1328

Persona de Contacto _____

Teléfono (_____) (800) 832-7839

Correo electrónico _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 4-13)

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Compañía THE TRAVELERS INSURANCE COMPANIES

PO BOX 2928

Dirección OVERLAND PARK, KS 66201-1328

Persona de Contacto _____

Teléfono (_____) (800) 832-7839

Correo electrónico _____



*Insurance Company, Third
Party Administrator, Service
Company, or Designated
Individual If Self- Insured*

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Name THE TRAVELERS INSURANCE COMPANIES
Address ONE TOWER SQUARE, HARTFORD CT 06183
Phone (800) 832-7839

EMPLOYEE INFORMATION

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the injury/or 30 days when reasonably aware of the work-relatedness of occupational illness or disease) by contacting

employer representative _____, *phone number* _____.

***Failure to do so may jeopardize your ability to receive benefits**

2. Seek medical attention (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need.

Visit www.labor.mo.gov/DWC or call 800-775-COMP.

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If an employee dies on the job, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage for the year immediately preceding the injury, along with funeral expenses up to \$5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please **visit www.labor.mo.gov/DWC**.

The Division of Workers' Compensation does not discriminate against individuals with disabilities as mandated by P.L. 101-336, The Americans With Disability Act. Alternative format available upon request.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or admitted self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer/insurer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workplace Safety

The Missouri Department of Labor offers free safety services to employers through its Missouri Workers' Safety Program (MWSP) to help employers reduce occupational injuries and workers' compensation costs.

Call 573-751-3403 or e-mail mwsp@labor.mo.gov for more information or for a registry of certified consultants and safety engineers. **Employees are urged to report all safety hazards or concerns to the Occupational Safety and Health Administration (OSHA) at 816-483-9531 or 314-425-4249.**

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence is a class D felony, punishable by a fine of up to \$10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Fraud – knowingly misrepresenting an employee's job classification to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class D felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to \$10,000. A subsequent violation is a class C felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class D felony, punishable by a fine of up to \$10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to \$50,000, whichever is greater. A subsequent violation is a class D felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of \$50 to \$1,000 or by imprisonment or both fine and imprisonment.



*Insurance Company, Third
Party Administrator, Service
Company, or Designated
Individual If Self- Insured*

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O.BOX 66852 ST. LOUIS, MO 63166-6852

Phone (800) 832-7839

EMPLOYEE INFORMATION

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Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the injury/or 30 days when reasonably aware of the work-relatedness of occupational illness or disease) by contacting

employer representative

phone number

***Failure to do so may jeopardize your ability to receive benefits**

2. Seek medical attention (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need.

Visit www.labor.mo.gov/DWC or call 800-775-COMP.

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If an employee dies on the job, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage for the year immediately preceding the injury, along with funeral expenses up to \$5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please **visit www.labor.mo.gov/DWC**.

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Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

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Workplace Safety

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Call 573-751-3403 or e-mail mwsp@labor.mo.gov for more information or for a registry of certified consultants and safety engineers. **Employees are urged to report all safety hazards or concerns to the Occupational Safety and Health Administration (OSHA) at 816-483-9531 or 314-425-4249.**

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence is a class D felony, punishable by a fine of up to \$10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class C felony.

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DIVISION OF

**WORKERS'
COMPENSATION**

Compañía aseguradora,
Administrador de Terceros,
Compañía de Servicios o
Persona designada si es
autoasegurada

División de Indemnización para el Trabajador de Missouri
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección ONE TOWER SQUARE, HARTFORD CT 06183

Teléfono (800) 832-7839

INFORMACIÓN PARA EL EMPLEADO

La División de Indemnización para el Trabajador de Missouri (DWC) administra programas para los trabajadores que se hayan lesionado en el trabajo o que presenten una enfermedad laboral derivada de su trabajo o que hayan desarrollado durante su trabajo. Los Jueces del Derecho Administrativo de la División tienen autoridad para aprobar acuerdos u otorgar indemnizaciones después de una audiencia en relación con el derecho que un empleado lesionado tenga a recibir beneficios.

Medidas que tomar cuando haya un accidente en el trabajo

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

(representante del empleador)

(teléfono)

***No hacerlo puede impedir que reciba beneficios**

2. Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

Ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Beneficios para empleados lesionados

Atención Médica:

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, inmediatamente póngase en contacto con su empleador o su aseguradora. El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

Pago de salarios perclidos:

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima mejoría médica"; de esto, lo que ocurría primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

Beneficios para los sobrevivientes:

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerales por hasta \$5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

Según lo exige la Ley de Derecho Público 101-336, la Ley para Estadounidenses con Discapacidades, la División de Indemnización para el Trabajador no discrimina a las personas que tengan alguna discapacidad. Disponemos de otros formatos previa solicitud.

Ley sobre Indemnización al Trabajador

Funciones y responsabilidades de los empleadores y los empleados

INFORMACIÓN PARA EL EMPLEADOR

Salvo algunas excepciones, se exige que todos los empleadores que tengan cinco empleados o más, así como los empleadores de la industria de la construcción con uno o más empleados, aseguren su responsabilidad de indemnización por accidentes laborales ya sea al adquirir una póliza o al conseguir autoridad para tener un autoseguro. El seguro de indemnización por accidentes laborales otorga beneficios a aquellos trabajadores que resulten lesionados en el trabajo. También se exige que los empleadores publiquen esta notificación en el lugar de trabajo para que los empleados la vean. El Artículo 287.127 de RS Mo exige este cartel que se encuentra disponible para los empleadores y compañías aseguradoras sin costo alguno si se comunican a la División al 800-775-Comp.

Medidas que hay que tomar cuando haya una lesión

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador **en un lapso de 30 días** a partir de que se sepa de la lesión.
3. Pague los gastos medicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o medico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
4. Para más información sobre la responsabilidad y el seguro en relación con el Programa de Indemnización por Accidentes Laborales, ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad en el lugar de trabajo

El Departamento del Trabajo de Missouri ofrece a los empleadores servicios gratuitos de seguridad mediante su Programa de Seguridad para los Trabajadores de Missouri (MWSP) con el fin de ayudarles a reducir las lesiones laborales y los gastos de indemnización por accidentes en el trabajo. Llame al 573-751-3403 o envíe un correo electrónico a mwsp@labor.mo.gov para obtener más información o para solicitar un registro de los asesores certificados y los ingenieros de seguridad. **Se exhorta a los empleados a que reporten todo riesgo o duda de seguridad a la Administración de Seguridad y Salud Ocupacional (OSHA) al 816-483-9531 o al 314-425-4249.**

Fraude/Incumplimiento

Fraude por parte del empleado – reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta \$10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Fraude por parte del empleador – falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta \$10,000. Una infracción posterior se considera delito grave clase C.

Fraude por parte de la compañía aseguradora – rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta \$10,000 o el doble del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Incumplimiento por parte del empleador – no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta \$50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de \$50 a \$1,000 o con encarcelamiento, o multa y encarcelamiento.



Compañía aseguradora,
Administrador de Terceros,
Compañía de Servicios o
Persona designada si es
autoasegurada

División de Indemnización para el Trabajador de Missouri
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección P.O.BOX 66852 ST. LOUIS, MO 63166-6852

Teléfono (800) 832-7839

INFORMACIÓN PARA EL EMPLEADO

La División de Indemnización para el Trabajador de Missouri (DWC) administra programas para los trabajadores que se hayan lesionado en el trabajo o que presenten una enfermedad laboral derivada de su trabajo o que hayan desarrollado durante su trabajo. Los Jueces del Derecho Administrativo de la División tienen autoridad para aprobar acuerdos u otorgar indemnizaciones después de una audiencia en relación con el derecho que un empleado lesionado tenga a recibir beneficios.

Medidas que tomar cuando haya un accidente en el trabajo

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

(representante del empleador)

(teléfono)

***No hacerlo puede impedir que reciba beneficios**

2. Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

Ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Beneficios para empleados lesionados

Atención Médica:

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, inmediatamente póngase en contacto con su empleador o su aseguradora. El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

Pago de salarios perclidos:

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima mejoría médica"; de esto, lo que ocurría primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

Beneficios para los sobrevivientes:

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerales por hasta \$5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

Según lo exige la Ley de Derecho Público 101-336, la Ley para Estadounidenses con Discapacidades, la División de Indemnización para el Trabajador no discrimina a las personas que tengan alguna discapacidad. Disponemos de otros formatos previa solicitud.

Ley sobre Indemnización al Trabajador

Funciones y responsabilidades de los empleadores y los empleados

INFORMACIÓN PARA EL EMPLEADOR

Salvo algunas excepciones, se exige que todos los empleadores que tengan cinco empleados o más, así como los empleadores de la industria de la construcción con uno o más empleados, aseguren su responsabilidad de indemnización por accidentes laborales ya sea al adquirir una póliza o al conseguir autoridad para tener un autoseguro. El seguro de indemnización por accidentes laborales otorga beneficios a aquellos trabajadores que resulten lesionados en el trabajo. También se exige que los empleadores publiquen esta notificación en el lugar de trabajo para que los empleados la vean. El Artículo 287.127 de RS Mo exige este cartel que se encuentra disponible para los empleadores y compañías aseguradoras sin costo alguno si se comunican a la División al 800-775-Comp.

Medidas que hay que tomar cuando haya una lesión

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador **en un lapso de 30 días** a partir de que se sepa de la lesión.
3. Pague los gastos medicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o medico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
4. Para más información sobre la responsabilidad y el seguro en relación con el Programa de Indemnización por Accidentes Laborales, ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad en el lugar de trabajo

El Departamento del Trabajo de Missouri ofrece a los empleadores servicios gratuitos de seguridad mediante su Programa de Seguridad para los Trabajadores de Missouri (MWSP) con el fin de ayudarles a reducir las lesiones laborales y los gastos de indemnización por accidentes en el trabajo. Llame al 573-751-3403 o envíe un correo electrónico a mwsp@labor.mo.gov para obtener más información o para solicitar un registro de los asesores certificados y los ingenieros de seguridad. **Se exhorta a los empleados a que reporten todo riesgo o duda de seguridad a la Administración de Seguridad y Salud Ocupacional (OSHA) al 816-483-9531 o al 314-425-4249.**

Fraude/Incumplimiento

Fraude por parte del empleado – reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta \$10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Fraude por parte del empleador – falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta \$10,000. Una infracción posterior se considera delito grave clase C.

Fraude por parte de la compañía aseguradora – rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta \$10,000 o el doble del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Incumplimiento por parte del empleador – no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta \$50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de \$50 a \$1,000 o con encarcelamiento, o multa y encarcelamiento.



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Nombre THE TRAVELERS INSURANCE COMPANIES

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Teléfono (800) 832-7839

INFORMACIÓN PARA EL EMPLEADO

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Medidas que tomar cuando haya un accidente en el trabajo

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

(representante del empleador)

(teléfono)

***No hacerlo puede impedir que reciba beneficios**

2. Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

Ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Beneficios para empleados lesionados

Atención Médica:

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, inmediatamente póngase en contacto con su empleador o su aseguradora. El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

Pago de salarios perclidos:

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima mejoría médica"; de esto, lo que ocurría primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

Beneficios para los sobrevivientes:

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerales por hasta \$5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

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Ley sobre Indemnización al Trabajador

Funciones y responsabilidades de los empleadores y los empleados

INFORMACIÓN PARA EL EMPLEADOR

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Medidas que hay que tomar cuando haya una lesión

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador **en un lapso de 30 días** a partir de que se sepa de la lesión.
3. Pague los gastos medicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o medico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
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Seguridad en el lugar de trabajo

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Fraude/Incumplimiento

Fraude por parte del empleado – reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta \$10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Fraude por parte del empleador – falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta \$10,000. Una infracción posterior se considera delito grave clase C.

Fraude por parte de la compañía aseguradora – rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta \$10,000 o el doble del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Incumplimiento por parte del empleador – no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta \$50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de \$50 a \$1,000 o con encarcelamiento, o multa y encarcelamiento.



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Medidas que tomar cuando haya un accidente en el trabajo

1. Avise inmediatamente a su empleador (se debe entregar notificación por escrito en un lapso de 30 días a partir del accidente/ o a los 30 días cuando se esté razonablemente consciente de la relación que la enfermedad laboral tenga con el trabajo), póngase en contacto con

(representante del empleador)

(teléfono)

***No hacerlo puede impedir que reciba beneficios**

2. Consiga atención médica (su empleador/la compañía aseguradora tienen la responsabilidad de proporcionar tratamiento médico y de pagar los gastos y honorarios médicos, a menos que usted decida que lo trate otro médico por su cuenta, sin la autorización de su empleador/aseguradora).
3. Consiga más información sobre los beneficios disponibles en el Programa de Indemnización por Accidentes Laborales o sobre lo que tiene que hacer para recibir los beneficios que necesita.

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Beneficios para empleados lesionados

Atención Médica:

Se exige que el empleador o la compañía aseguradora proporcionen tratamiento médico y atención que alivie y mitigue los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. No hay deducible; el empleador o la aseguradora para la indemnización por accidentes laborales cubrirán todos los gastos. Si usted recibe una cuenta, inmediatamente póngase en contacto con su empleador o su aseguradora. El empleador/La aseguradora tienen derecho a escoger al proveedor de atención médica o médico de cabecera. Usted puede escoger a otro proveedor de atención médica o médico de cabecera; pero al hacerlo, es posible que sea por su cuenta.

Pago de salarios perclidos:

- Si el médico le dice que usted no puede trabajar a causa de sus lesiones o para recuperarse de una cirugía, podrá tener derecho a beneficios por **discapacidad total temporal** (TTD). Si el médico le dice que puede desempeñar deberes laborales leves o modificados y su empleador se lo ofrece, es posible que no tenga derecho a los beneficios por TTD. Estos beneficios deben continuar hasta que el médico indique que usted ya puede regresar a trabajar o cuando ya haya concluido su tratamiento puesto que su condición de salud ha logrado "la máxima mejoría médica"; de esto, lo que ocurría primero.
- Si usted regresa para desempeñar tareas leves o modificadas y percibe menos de su salario, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enfermedad da como resultado una discapacidad permanente, es posible que tenga derecho a recibir beneficios por discapacidad ya sea parcial permanente o total permanente.

Beneficios para los sobrevivientes:

Si un empleado fallece en el trabajo, sus dependientes que le sobrevivan pueden recibir beneficios semanales por deceso que se paguen a 66 2/3% del salario semanal promedio del empleado en el año inmediato anterior al accidente, además de gastos funerales por hasta \$5,000 del empleador/la aseguradora. Para más información sobre los beneficios para los sobrevivientes, incluyendo las oportunidades de becas universitarias para los hijos, ingrese a www.labor.mo.gov/DWC.

Según lo exige la Ley de Derecho Público 101-336, la Ley para Estadounidenses con Discapacidades, la División de Indemnización para el Trabajador no discrimina a las personas que tengan alguna discapacidad. Disponemos de otros formatos previa solicitud.

Ley sobre Indemnización al Trabajador

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INFORMACIÓN PARA EL EMPLEADOR

Salvo algunas excepciones, se exige que todos los empleadores que tengan cinco empleados o más, así como los empleadores de la industria de la construcción con uno o más empleados, aseguren su responsabilidad de indemnización por accidentes laborales ya sea al adquirir una póliza o al conseguir autoridad para tener un autoseguro. El seguro de indemnización por accidentes laborales otorga beneficios a aquellos trabajadores que resulten lesionados en el trabajo. También se exige que los empleadores publiquen esta notificación en el lugar de trabajo para que los empleados la vean. El Artículo 287.127 de RS Mo exige este cartel que se encuentra disponible para los empleadores y compañías aseguradoras sin costo alguno si se comunican a la División al 800-775-Comp.

Medidas que hay que tomar cuando haya una lesión

1. Asegúrese de que se administren primeros auxilios al empleado y que lo lleven al médico o a un hospital para que reciba más atención médica en caso de ser necesario.
2. Reporte el accidente laboral a la compañía aseguradora o al Administrador de Terceras Personas (TPA) en un lapso de cinco días a partir de la fecha de la lesión o cinco días a partir de la fecha en que el empleado lo haya reportado al empleador, lo que suceda en segundo término. La aseguradora, el TPA o el autoseguro reconocido tienen la responsabilidad de presentar un Primer Informe de Accidente Laboral a la División de Indemnización para el Trabajador **en un lapso de 30 días** a partir de que se sepa de la lesión.
3. Pague los gastos medicos en relación con el accidente laboral a fin de subsanar al empleado de los efectos de la lesión. Esto incluye todos los gastos del tratamiento médico autorizado, recetas y aparatos médicos. El empleador/La aseguradora tiene derecho a escoger al proveedor de atención médica o medico de cabecera. (El empleado puede elegir a otro proveedor de atención médica o médico de cabecera, pero si lo hace, es posible que sea por su cuenta).
4. Para más información sobre la responsabilidad y el seguro en relación con el Programa de Indemnización por Accidentes Laborales, ingrese a www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad en el lugar de trabajo

El Departamento del Trabajo de Missouri ofrece a los empleadores servicios gratuitos de seguridad mediante su Programa de Seguridad para los Trabajadores de Missouri (MWSP) con el fin de ayudarles a reducir las lesiones laborales y los gastos de indemnización por accidentes en el trabajo. Llame al 573-751-3403 o envíe un correo electrónico a mwsp@labor.mo.gov para obtener más información o para solicitar un registro de los asesores certificados y los ingenieros de seguridad. **Se exhorta a los empleados a que reporten todo riesgo o duda de seguridad a la Administración de Seguridad y Salud Ocupacional (OSHA) al 816-483-9531 o al 314-425-4249.**

Fraude/Incumplimiento

Fraude por parte del empleado – reclamar deliberadamente los beneficios de indemnización por accidente laboral a los cuales un(a) empleado(a) no tenga derecho o presentar deliberadamente múltiples reclamaciones por el mismo suceso son delitos graves clase D que son penados con una multa de hasta \$10,000 o el doble del valor del fraude; de estos, el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Fraude por parte del empleador – falsear deliberadamente la clasificación del trabajo de un empleado con el fin de obtener un seguro por menos del valor correcto es un delito menor clase A. Una infracción posterior se considera delito grave clase D. El empleador que deliberadamente haga una declaración falsa o fraudulenta sobre el derecho que un empleado tenga a beneficios, con el fin de evitar este que haga una reclamación legítima, o el que deliberadamente haga una declaración material falsa o fraudulenta que niegue beneficios a un trabajador, será culpable de un delito menor clase A penado con una multa de hasta \$10,000. Una infracción posterior se considera delito grave clase C.

Fraude por parte de la compañía aseguradora – rehusarse deliberada e intencionalmente a cumplir con las obligaciones en cuanto a la indemnización por accidente laboral que la aseguradora o el autoasegurado saben que es derecho de un empleado, es un delito grave clase D penado con una multa de hasta \$10,000 o el doble del fraude; de estos el monto que sea mayor. Una infracción posterior se considera delito grave clase C.

Incumplimiento por parte del empleador – no asegurar deliberadamente la indemnización al trabajador según las leyes constituye un delito menor clase A penado con una multa de hasta tres veces la prima anual que el empleador habría pagado si la hubiera asegurado o de hasta \$50,000; de estos lo que sea mayor. Una infracción posterior se considera delito grave clase D. El empleador que premeditadamente no exhiba en el lugar de trabajo la notificación sobre la indemnización por accidentes laborales será culpable de un delito menor clase A penado con una multa de \$50 a \$1,000 o con encarcelamiento, o multa y encarcelamiento.

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To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: <http://govcha.state.nv.us>, E-mail cha@govcha.state.nv.us

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State of New Mexico Workers' Compensation Administration
WORKERS' COMPENSATION ACT

**If You Are Injured At Work
Si Se Lastima En El Trabajo**

- 1) **Notice** – In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.
- 2) You have the right to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.
- 3) Claims information – Contact your employer's Claims Representative.
- 1) Aviso. – En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.
- 2) Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.
- 3) Información acerca de Reclamaciones. – Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer/Claims Representative:

Name: THE TRAVELERS INSURANCE COMPANIES

Phone #: (800) 832-7839

Address: 6001 INDIAN SCHOOL NE SUITE 300 ALBUQUERQUE, NM 87110

Note: Employer must fill in this insurer/claims representative information.



WCA POSTER (TOP)
PART 1 OF 2
ATTACH BOTTOM OF POSTER HERE

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer/insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer/insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than 7 days, your employer/insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Las Cruces:	Las Vegas:	Livington:	Roswell:	Santa Fe:
1-800-255-7965	1-800-568-7310	1-800-870-6826	1-800-281-7889	1-800-934-2450	1-866-311-8587	1-505-476-7381
1-505-841-6000	1-505-599-9746	1-505-524-6246	1-505-454-9251	1-505-396-3437	1-505-623-3997	

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: www.workerscomp.state.nm.us

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it.

This poster without Notice of Accident forms does not comply with law.

You have other rights and duties under the law.



POST FORMS HERE

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador/asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador/asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador/asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

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Roswell:

Santa Fe:

1-505-476-7381

1-505-623-3997



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PART 2 OF 2

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

W30P1008
W30P1008

This poster published 3/15/07. It remains valid until
reissued and supersedes all prior versions except 3/15/03.

State of New Mexico Workers' Compensation Administration
WORKERS' COMPENSATION ACT

**If You Are Injured At Work
Si Se Lastima En El Trabajo**

- 1) **Notice** – In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.
 - 2) You have the right to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.
 - 3) Claims information – Contact your employer's Claims Representative.
- 1) Aviso. – En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.
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 - 3) Información acerca de Reclamaciones. – Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer/Claims Representative:

Name: THE TRAVELERS INSURANCE COMPANIES

Phone #: (800) 832-7839

Address: 6001 INDIAN SCHOOL NE SUITE 300 ALBUQUERQUE, NM 87110

Note: Employer must fill in this insurer/claims representative information.



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PART 1 OF 2
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YOUR RIGHTS

If you are injured in a work-related accident:

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You may or may not have the right to choose your health care provider. If your employer/insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

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If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

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Albuquerque:	Farmington:	Las Cruces:	Las Vegas:	Livington:	Roswell:	Santa Fe:
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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.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

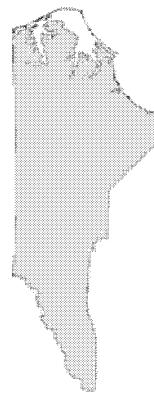
- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed \$2,000.00.
- Give a copy 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



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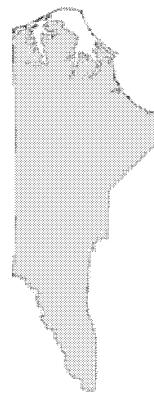
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TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-33).

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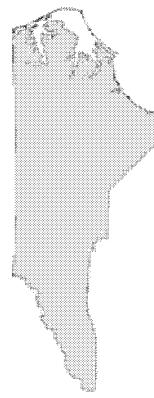
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**EMPLEADOR: ESTA INFORMACIÓN DEBE ESTAR PROMINENTEMENTE VISIBLE.
REGLA 201 DE LA COMISIÓN INDUSTRIAL**

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, excepto oficiales ejecutivos expresamente excluidos.

— INFORMACIÓN IMPORTANTE EN CASO DE UNA LESIÓN O ENFERMEDAD OCUPACIONAL —

El empleado deberá:

1. Notificar inmediatamente por escrito al empleador sobre la lesión o enfermedad ocupacional. El no informar al empleador dentro de los treinta (30) días después de una lesión o desarrollo de una enfermedad ocupacional, 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 reclamo 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 un desacuerdo en cuanto se debe de la compensación, el empleado lo más pronto posible debe pedir una audiencia a la Comisión Industrial para que decidan 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.
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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 incapacidad 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) días de ocurrido el reporte de una lesión que causa la ausencia del empleado por más de un (1) día o \$2,000.00 o más en tratamiento médico, excluyendo tratamientos provistos en el trabajo. N.C.G.S. §97-92.
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Información sobre alivio médico y monetario por lesiones ocurridas en el empleo.

NORTH CAROLINA INDUSTRIAL COMMISSION
4340 MAIL SERVICE CENTER
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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, excepto oficiales ejecutivos expresamente excluidos.

— INFORMACIÓN IMPORTANTE EN CASO DE UNA LESIÓN O ENFERMEDAD OCUPACIONAL —

El empleado deberá:

1. Notificar inmediatamente por escrito al empleador sobre la lesión o enfermedad ocupacional. El no informar al empleador dentro de los treinta (30) días después de una lesión o desarrollo de una enfermedad ocupacional, 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 reclamo 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 un desacuerdo en cuanto se debe de la compensación, el empleado lo más pronto posible debe pedir una audiencia a la Comisión Industrial para que decidan 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.
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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 incapacidad 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) días de ocurrido el reporte de una lesión que causa la ausencia del empleado por más de un (1) día 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 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 aprobación.
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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

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] coverage from [Name of commercial insurance company]. THE TRAVELERS INSURANCE COMPANIES In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 04-01-14 . Any injuries or occupational diseases which occur on or after that will be handled by [name of commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES 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.

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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

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] coverage from [Name of commercial insurance company]. THE TRAVELERS INSURANCE COMPANIES In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 04-01-14 . Any injuries or occupational diseases which occur on or after that will be handled by [name of commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES 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

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Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
cional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] 04-01-14 . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy].

THE TRAVELERS INSURANCE COMPANIES

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).

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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).

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NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES

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THE TRAVELERS INSURANCE COMPANIES

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EMPLEADOR CON COBERTURA

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NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
cional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] 04-01-14 . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy].

THE TRAVELERS INSURANCE COMPANIES

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
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GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
cional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] 04-01-14 . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy].

THE TRAVELERS INSURANCE COMPANIES

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EMPLEADOR CON COBERTURA

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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
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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
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THE TRAVELERS INSURANCE COMPANIES

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES
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GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
compensación para trabajadores con [name of the commercial insurance company]

THE TRAVELERS INSURANCE COMPANIES

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THE TRAVELERS INSURANCE COMPANIES

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GARDEN FRESH RESTAURANT CORP

COBERTURA: [Name of the employer]
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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 requisitos 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



NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

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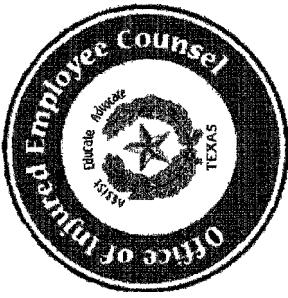
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AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que ayuda a los empleados que no cuentan con representación legal con sus reclamaciones en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-EZE-OIEC (1-866-393-6432). Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio Web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

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¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que puede asistirle si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation). Una vez que el procedimiento haya sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

Código Administrativo de Texas No. 28 (28 Texas Administrative Code – TAC, por su nombre y siglas en inglés) §276.5. Aviso del Empleado sobre el Programa de Ombudsman para los Empleados (A partir de 9/1/13)

(a) Todos los empleadores que participan en el sistema de compensación para trabajadores deberán mostrar el aviso sobre el Programa de Ombudsman de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC). Este aviso deberá ser mostrado en la oficina de personal, si es que el empleador cuenta con una oficina de personal, y en el área de trabajo donde cada empleado probablemente podrá ver el aviso de manera regular.

(b) Este aviso deberá contener el texto que es proporcionado por OIEC sin ninguna palabra adicional o cambios y se puede obtener:

- (1) Descargando el formulario del sitio Web de OIEC en: www.oiec.texas.gov; o
- (2) Solicitando el aviso llamando al número de teléfono gratuito de OIEC al: 1-866-EZE-OIEC (1-866-393-6432).



AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que ayuda a los empleados que no cuentan con representación legal con sus reclamaciones en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-EZE-OIEC (1-866-393-6432). Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio Web de la agencia (www.oiec.texas.gov).

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WORKERS' COMPENSATION NOTICE

THAT

GARDEN FRESH RESTAURANT CORP

Employer: _____

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act

by insuring with **Insurance Carrier:** THE TRAVELERS INSURANCE COMPANIES

Policy Number: (TRJUB-4246B09-2-14)

Address for the above insurance carrier is P.O. BOX 173762

DENVER, CO 80217-3762

Telephone number is 1-800-832-7839

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury – no matter how slight – to your boss immediately. (You may lose your rights if your injury is not reported within 180 days of injury or work related illness.)
2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.
3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.
2. Ask your doctor to send a medical report to that insurance company.
3. Ask your employer to send a report of the accident to that insurance company.
4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM – CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison".

STATE OF UTAH



LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

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COMPENSACIÓN AL TRABAJADOR

NOTE QUE

GARDEN FRESH RESTAURANT CORP

La empresa:

Ha cumplido con las provisiones del Acta de Compensación al Trabajador, Titulo §34A-2-101, en el libro de Código de Utah anotado en 1997, y las reglas de la Comisión de Labor (Labor Commission), y ha asegurado tener la responsabilidad de pagar compensación y otros beneficios previamente idos por el Acta ya mencionada al tener cobertura con.

Compañía de Seguros: THE TRAVELERS INSURANCE COMPANIES

No. de Póliza: (TRJUB-4246B09-2-14)

Dirección de la compañía de seguros: P.O. BOX 173762

DENVER, CO 80217-3762

Número de teléfono: 1-800-832-7839

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – su supervisor inmediatamente. (Pierde sus derechos no reporta su accidente entre 180 días después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compañía de seguro dentro de los primeros siete (7) días del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatamente para obtener tratamiento. Si no, vaya al doctor de su preferencia.
4. Digale al doctor CÓMO, CUÁNDO Y DÓNDE ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben ser enviadas dentro de siete (7) días de su visita a (1) la compañía de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah requiere lo siguiente que aparezca en esta forma, cualquier persona que intencionadamente presente información falsa o fraudulenta, que abra o cause que sea abierto un caso fraudulento de discapacidad o beneficios médicos, o que entregue un reporte fraudulento de facturas de gastos médicos u otros servicios profesionales es calponible de crimen y puede ser sujeto a multas y encarcelado en la prisión del Estado."

ESTADO DE UTAH



COMISION LABORAL

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensación al Trabajador o si tiene preguntas, llame a la Comisión Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Artículo §34A-2-204, en el libro de Código de Utah anotado en 1997.

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DENVER, CO 80217-3762

Número de teléfono: 1-800-832-7839

COMPENSACIÓN AL TRABAJADOR

ES EL SEGURO EL CUAL LE PROTÉGÉ DURANTE EL TRABAJO. SI TIENE UN ACCIDENTE EN EL TRABAJO O UNA ENFERMEDAD GENERADA A CAUSA DE SU TRABAJO, SU SEGURO PAGARA POR: HOSPITAL Y GASTOS MEDICOS * INCAPACIDAD * PERDIDA PERMANENTE DE UNA FUNCION DE SU CUERPO * PROTESIS * GASTOS DEL FUNERAL EN CASO DE MUERTE.

COMO REPORTAR UNACCIDENTE

1. Reporte la lesión – no importa que tan leve sea – su supervisor inmediatamente. (Pierde sus derechos no reporta su accidente entre 180 días después del incidente.)
2. Pida a su supervisor que llene la forma del primer reporte de accidente. Una copia de este reporte es para usted y las demás copias deben ser enviadas a La Comisión Laboral a la compañía de seguro dentro de los primeros siete (7) días del accidente.
3. Si en su trabajo hay un cuarto de primeros auxilios o un doctor de la compañía, vaya inmediatamente para obtener tratamiento. Si no, vaya al doctor de su preferencia.
4. Digale al doctor CÓMO, CUÁNDO Y DÓNDE ocurrió el accidente. El doctor llenara una forma de reporte médico. Copias de ese reporte deben ser enviadas dentro de siete (7) días de su visita a (1) la compañía de seguros, (2) La Comisión Laboral (3) usted, el empleado.

COMO EMPREZAR LA COMPENSACIÓN

1. Pregunte a su supervisor cual es la compañía de seguros que paga Compensación al Trabajador de su trabajo.
2. Pida a su doctor que mande un reporte médico a esa compañía de seguros.
3. Pida a su supervisor que mande un reporte del accidente a esa compañía de seguros.
4. Llame a la compañía de seguros y pidales que empiecen sus beneficios de compensación al trabajador. La compañía de seguros requerirá el reporte del doctor, el reporte de su trabajo, y le pedirá que llene una forma para obtener compensación.

REHABILITACION

SI NO PUEDE REGRESAR A SU TRABAJO, USTED PUEDE CALIFICAR PARA UN PROGRAMA DE REHABILITACION – LLAME A LA COMPAÑIA DE SEGUROS MENCIONADA ARRIBA.

FRAUDE

"Para su protección, la ley de Utah requiere lo siguiente que aparezca en esta forma, cualquier persona que intencionadamente presente información falsa o fraudulenta, que abra o cause que sea abierto un caso fraudulento de discapacidad o beneficios médicos, o que entregue un reporte fraudulento de facturas de gastos médicos u otros servicios profesionales es calponible de crimen y puede ser sujeto a multas y encarcelado en la prisión del Estado."

ESTADO DE UTAH



COMISION LABORAL

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 – (800)530-5090

Si desea una Guía del Empleado para Compensación al Trabajador o si tiene preguntas, llame a la Comisión Labor a los números mencionados arriba.

NOTA: Esta información debe ser publicada y permanecer continuamente colocada en un lugar público ya sea en la oficina, taller, o lugar de negocio de la empresa de acuerdo con el Artículo §34A-2-204, en el libro de Código de Utah anotado en 1997.

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NAME INSURED: GARDEN FRESH RESTAURANT CORP

POLICY NUMBER: (TRJUB-4246B09-2-14)

EFFECTIVE DATE: 04-01-14

GUNTHER OPERATOR:

MANUALLY INSERT 55 COPIES OF W04P1

CALIFORNIA OVERSIZED POSTING NOTICE

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POLICY NUMBER: (TRJUB-4246B09-2-14)

EFFECTIVE DATE: 04-01-14

GUNTHER OPERATOR:

**MANUALLY INSERT 5 COPIES OF THE
COLORADO OVERSIZED POSTING NOTICE
CP-5992 – YELLOW CARD STOCK**

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NAMED INSURED: GARDEN FRESH RESTAURANT CORP

POLICY NUMBER: (TRJUB-4246B09-2-14)

EFFECTIVE DATE: 04-01-14

**GUNTHER OPERATOR:
MANUALLY INSERT 31 COPIES OF THE
FLORIDA OVERSIZED POSTING NOTICES
W09P1 — (ENGLISH)
AND
W09P2 — (SPANISH)**

ATTACH STICKERS THAT MATCH DATA BELOW:

**EMPLOYER—Name: GARDEN FRESH RESTAURANT CORP
15822 BERNARDO CENTER DRIVE
Address: SAN DIEGO CA 92127**

**CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES
Address: (VARIES BY LOCATION)**

AGENT—Name: LOCKTON COMPANIES LLC

POLICY NUMBER: (TRJUB-4246B09-2-14)

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NAMED INSURED: GARDEN FRESH RESTAURANT CORP

POLICY NUMBER: (TRJUB-4246B09-2-14)

EFFECTIVE DATE: 040114

GUNTHER OPERATOR:

MANUALLY INSERT 5 COPIES OF W27P1

NEVADA OVERSIZED POSTING NOTICES

ATTACH NEVADA STICKERS

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STICKER LABELS AND/OR POSTING NOTICES FOR MANUAL INSERT

FOR POLICY PRINTED IN JOB #: G664062

Named Insured: GARDEN FRESH RESTAURANT CORP

Policy Number: (TRJUB-4246B09-2-14)

Effective Date: 04-01-14

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ORLANDO, FL 32802-0715

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Eff. Date: 04-01-14
Exp. Date: 04-01-15

EMPLOYER – Name: GARDEN FRESH RESTAURANT CORP
15822 BERNARDO CENTER DRIVE
Address: SAN DIEGO CA 92127

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES
Address: P.O. BOX 715
ORLANDO, FL 32802-0715

AGENT – Name: LOCKTON COMPANIES LLC
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Eff. Date: 04-01-14
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Exp. Date:
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ISSUED TO: GARDEN FRESH RESTAURANT CORP

ISSUED TO: GARDEN FRESH RESTAURANT CORP

INSURER/	
ADMINISTRATOR:	CLAIM MANAGER
CONTACT PERSON:	CLAIM MANAGER
Address:	P. O. BOX 14246 ORANGE, CA 92863-1246
Telephone No.	1-800-832-7839

ISSUED TO: GARDEN FRESH RESTAURANT CORP
INSURER/
ADMINISTRATOR: CLAIM MANAGER
CONTACT PERSON: CLAIM MANAGER
Address: P.O. BOX 14246
ORANGE, CA 92863-1246
Telephone No. 1-800-832-7839

ISSUED TO: GARDEN FRESH RESTAURANT CORP

INSURER/
ADMINISTRATOR: CLAIM MANAGER

CONTACT PERSON:
Address: CLAIM MANAGER
P. O. BOX 14246
ORANGE, CA 92863-1246

Telephone No. 1-800-832-7839

ISSUED TO:	GARDEN FRESH RESTAURANT CORP
INSURER/ ADMINISTRATOR:	CLAIM MANAGER
CONTACT PERSON:	Address:
	Telephone No.

INSURER/ ADMINISTRATOR:	CLAIM MANAGER
CONTACT PERSON:	CLAIM MANAGER
Address:	P.O. BOX 14246 ORANGE, CA 92863-1246
Telephone No.	1-800-832-7839

ISSUED TO:	GARDEN FRESH RESTAURANT CORP		
INSURER/	CLAIM MANAGER		
INSTITUTE:			
ACT PERSON:	CLAIM MANAGER		
Address:	P.O. BOX 14246		
	ORANGE, CA 92863-1246		
		Telephone No.	1-800-832-7839

ISSUED TO: GARDEN FRESH RESTAURANT CORP
INSURER/INSTRATOR: CLAIM MANAGER
CONTACT PERSON: Address: _____
Telephone No. _____

ISSUED TO: GARDEN FRESH RESTAURANT CORP
INSURER/ADMINISTRATOR: CLAIM MANAGER
CONTACT PERSON: Address: _____
Telephone No. _____



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
OVERPRINT PAGE

POLICY NUMBER: (TRJUB-4246B09-2-14)

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

POLICY EFFECTIVE: 04-01-14

POLICY EXPIRY: 04-01-15

NEW/RENEWAL: R

SOLICITOR:

SAI: 8027K3068

RESPONSIBILITY: S

MSI:

SIC CODE: 5812

PAYMODE/ DIRECT BILL CODE: X

AUDIT FREQUENCY: A

REINSURANCE:

WATCH FILE:

SURVEY CODE: 0

NEG COMM: .0000

PROGRAM CODE:

NBR OF POL IN SAI:

AGENCY BILL: N

AMS BINDER #: 236704

PARENT FEIN: 330028786

NAICS: 722511

PKG POL NBR:

STATE PREDOMINANT CLASS & SYMBOL (* indicates if selected as Policy predominant)

ST	ST POLICY SYMBOL	ST PREDOM CLASS	ST	ST POLICY SYMBOL	ST PREDOM CLASS
AZ	TRKUB	9083	CA	TRJUB *	9079
CO	TRKUB	9083	FL	TROUB	9083
GA	TRHUB	9083	IL	TRJUB	9083
KS	TRHUB	9083	MO	TRHUB	9083
NC	TRNUB	9083	ND	TRJUB	8742
NM	TRNUB	9083	NV	TROUB	9083
OH	TRJUB	8742	OR	TROUB	9079
TX	TRKUB	9079	UT	TRNUB	9083
WA	TRJUB	9079	WY	TRJUB	8742

OFFICE: LOS ANGELES CA 105

PRODUCER: LOCKTON COMPANIES LLC NA287 RATER: LC

ISSUE DATE: 04-15-14 CHANGE EFFECTIVE DATE: 04-01-14

WUNT6H96



ONE TOWER SQUARE
HARTFORD, CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

CHANGE DOCUMENT WC 99 99 98 (00)

POLICY NUMBER: (TRJUB-4246B09-2-14)

CHANGE EFFECTIVE DATE: 04-01-14

NCCI CO CODE: 13579

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: GARDEN FRESH RESTAURANT CORP

This change is issued by that member of The Travelers Insurance Companies which issued the policy and forms a part of the policy. It is agreed that the policy is amended as follows:

An absence of an entry in the premium spaces below means that the premium adjustment, if any, will be made at time of audit.

ADDITIONAL PREMIUM \$
ADDITIONAL NON-PREMIUM \$

RETURN PREMIUM \$
RETURN NON-PREMIUM \$

The following endorsements are added:

WC 89 04 06 (00)-001
WC 89 06 14 (00)-001

DATE OF ISSUE: 04-22-14 MM CHANGE NO: 001 PAGE 001 OF LAST
POL. EFF. DATE: 04-01-14 POL. EXP. DATE: 04-01-15
OFFICE: LOS ANGELES CA 105
PRODUCER: LOCKTON COMPANIES LLC NA287

COUNTERSIGNED AGENT



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 89 04 06 (00) - 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

**POLICY INFORMATION PAGE
ENDORSEMENT**

The Experience Modification is changed to read:

STATE	EXPERIENCE MODIFICATION	STATE	EXPERIENCE MODIFICATION
CA	1.340		

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

DATE OF ISSUE: 04-22-14

ST ASSIGN:



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 89 06 14 (00) – 001

POLICY NUMBER: (TRJUB-4246B09-2-14)

**POLICY INFORMATION PAGE
ENDORSEMENT**

Item 3.D. Endorsement numbers is changed to read:

WC89040600
WC89061400

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED.

DATE OF ISSUE: 04-22-14

ST ASSIGN: