Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

PULL POSTING NOTICE
FOR THE STATE OF:

COLORADO
FLORIDA
FLORIDA
GEORGIA
MARYLAND
MARYLAND
NEW YORK
FLORIDA
FLORIDA
GEORGIA
GEORGIA
MARYLAND
NEW MEXICO

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

MEDSPEED, LLC
140 INDUSTRIAL DR.
ELMHURST IL 60126

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

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

Named Insured: **MEDSPEED, LLC**

Effective Date: **12/31/2020**

Agency Name: **CLAUDIA MANDATO**

Welcome

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

Our Company

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

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

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

Terms and Agreements

See your policy for Terms and Agreement information.

STARR INDEMNITY

A MEMBER OF STARR COMPANIES

WORKERS COMPENSATION CLAIMS REPORTING

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

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

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

- **CLIENT /PROGRAM NAME:** MEDSPEED, LLC
- **POLICY NUMBER:** 100 0004019
- **TPA NAME:** GALLAGHER BASSETT SERVICES INC
- **TPA CLIENT CODE NUMBER:** VDN2119
- **TPA EMAIL:** tnwclaims@tnwinc.com
- **TPA FAX NUMBER:** 800-748-6159
- **TPA MAILING ADDRESS:** 2915 Premiere Parkway, ST 350

  Duluth GA 30097-5241
- **TPA TELEPHONE NUMBER:** 855-782-7750

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

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER **STARR INDEMNITY & LIABILITY CO**

TELEPHONE NUMBER **(646)227-6563**

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED
IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

Estado de Alabama

Información de Compensación de Trabajadores

Si se lesiona en el trabajo, o tiene una enfermedad ocupacional, notifique a su empleador inmediatamente.

if you are injured on the job, or contract an occupational disease, notify your employer immediately.

Su empleador le aconsejará a que médico tiene que consultar para tratamiento médico autorizado.

your employer will advise you of the physician to see for authorized medical treatment.

Portador de Seguro de Compensación al Trabajador: **STARR INDEMNITY & LIABILITY CO**

Workers' Compensation Insurance Carrier

Número de Teléfono: **(646)227-6563**

Telephone number

La asistencia está disponible bajo la Ley de Compensación de Trabajadores de Alabama, incluyendo el servicio de mediación.

Assistance is available under the Alabama Workers' Compensation Law including mediation service.

Para más información llame al:

For information call:

1-800-528-5166

Alabama Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

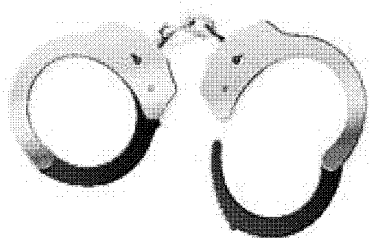
Código de Alabama, 1975, 25-5-290(d), requiere que este aviso se publique en uno o más lugares visibles en su negocio.

Code of Alabama, 1975, 25-5-290(d), requires that this notice be posted in one or more conspicuous places in your business.

UNEMPLOYMENT COMPENSATION FRAUD IS A CRIME

Some examples of fraud include:

- Making false statements to obtain unemployment compensation
- Attempting to draw benefits while working
- Continuing to file a claim after returning to work
- Being paid "under the table" while collecting unemployment compensation
- Not being truthful when filing your initial or weekly claims

FRAUD IS  STEALING!

FRAUD PENALTIES ARE SEVERE

- Up to a Class B Felony
- Fines of up to $500 *AND* up to 12 months in jail for each fraudulent week claimed
- Mandatory ineligibility for up to a two year period

ALABAMA DEPARTMENT OF LABOR

TENNESSEE
MISSISSIPPI
GEORGIA
FLORIDA

I SEC
POSTER-
1 CAT#52405

To report fraud call 800-392-8019

Penalties noted above subject to Section 25-4-145 Code of Alabama (1975)

TO BE POSTED BY EMPLOYER **POLICY NUMBER** 100 0004019

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

STARR INDEMNITY & LIABILITY CO

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 blanks and forms for such notice are available to all employees at the office of this employer.

* * * * * * * * * * * * * *

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION DE OBREROS DE ARIZONA

Se participa a todos los empleados que este patron ha cumplido con las provisiones de la Ley de Compensacion de Obreros de Arizona (Titulo 23, del Capitulo 6, Revision de Estatutos de Arizona) como enmendado, y todos los reglamentos, de la Comision Industrial de Arizona hechos en prosecucion de esto, y ha procurado el pago de compensacion a los empleados asegurando el pago de dicha compensacion con el.

STARR INDEMNITY & LIABILITY CO

Todos empleados por este medio son notificados ademas que en caso de que no rechazen especificamente las provisiones de dicha ley de compensacion obligatoria quedan considerados por las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber elejido de aceptar compensacion bajo los terminos de esto; y que bajo los terminos de esto, empleados tienen el derecho de rechazar lo mismo por medio de noticia escrita antes de recibir cualquier perjuicio, y blancos y formas para dicho aviso son disponible a todos empleados en la oficina de este patron.

* * * * * * * * * * * * * *

KEEP POSTED IN A CONSPICUOUS PLACE

TO BE POSTED BY EMPLOYER **POLICY NUMBER** 100 0004019

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STARR INDEMNITY & LIABILITY CO

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* * * * * * * * * * * * * *

KEEP POSTED IN A CONSPICUOUS PLACE

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (ADS) & 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), Aquired 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 DAY**S 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 HJV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (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 employy 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

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KEEP POSTED IN CONSPICUOUS PLACE

NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

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 par *una* condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Sindrome do Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las regias de La Comisión Industrial de Arizona. Tal reclamación debe incluir el sucesa de una exposición importante en el trabajo, la que per lo general significa contacto do alguna ruptura de la piel a mucosa del empleado con la sangre. semen, fluido vaginal, fluido(s) quirúrgico(s)(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 a usa ilicito de drogas

Ciertas clases de empleados pueden establecer mas facilmente una reclamación relacionada con el VIH SIDA o Hepatitis C si reunen los requisitos siguientes:

1. El cursa regular del empleo del empleado requiere el manejo de o la exposición a sangre, semen, fluido vaginal, fluido(s) quirúrgico(s)(s) o cualquier otro fluido que contenga sangre. Incluidos en esta categoría son los proveedores do cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, tecnicos medicos de emergencia, paramedicos y-agentes correccionales.

2. **NO MAS DE DIEZ (10) DÍAS DE CALENDARIO** después de una posible exposición importante que resulta de y en el curso de su trabajo. el empleado reporta a su patrón per escrita los detalles de in exposición coma lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 8500?, (602) *542 —4661* o *2675* E. Broadway, Tucson, Arizona 85716, *(520)* 628-5188. Si un empleado elige no llenar la farina de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. **NO MAS DE DIEZ (10) DÍAS DE CALENDARIO** después de una posible exposición importante el empleado va a quo le saquen sangre, y **NO MAS DE TREINTA** (20) **DÍAS DE CALENDARIO** In sangre es analizada para **VIH 0 HEPATITIS C** par media do análisis do 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 las resultados del análisis son positivos par VIH a el empleado ha sido diagnosticado coma positivo par la presencia de VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la positivo exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivas por La presencia de Hepatitis C a el empleada ha sido diagnosticado coma positivo par la presencia de Hepatitis C.

MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACIÓN PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISIÓN INDUSTRIAL
DE ARIZONA PARA USO DE LAS ASEGURADORAS

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

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MANTENER FIJO EN UN LUGAR SOBRESALIENTE JUNTO AL AVISO A LOS EMPLADOS SOBRE COMPENSACIÓN PARA TRABAJADORES

ESTE AVISO HA SIDO APROBADO POR LA COMISIÓN 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.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

WORK EXPOSURE TO METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

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CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING BUREAU ("WCIRB")
COMMUNICATION REQUIRING REPORTING OF ALL INSURED FIRST AID CLAIMS
EFFECTIVE JANUARY 1, 2017

The California WCIRB issued the attached Bulletin, which clarifies the reporting requirements for Small Medical Only or First Aid Claims. This was approved by the CA Insurance Commissioner on October 14, 2016.

Small Medical Only or First Aid Claims:

Small Medical Only or First Aid Claims are defined in California Labor Code Section 5401(a) as follows:

> "first aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, or other minor industrial injury, which do not ordinarily require medical care. This one-time treatment, and follow-up visit for the purpose of observation, is considered first aid even though provided by a physician or registered professional personnel.

Reporting Requirement Clarifications and Reasons:

The above definition of first aid has now been added to the *California Workers' Compensation Uniform Statistical Reporting Plan – 1995* which became effective January 1, 2017. This clarifies that first aid or small medical only claims must be reported if medical care is provided and costs are incurred, regardless of whether the payments are made by an insurer or insured. These claims can be reported like any other previously reported medical only claim.

The WCIRB has issued prior bulletins in this regard and the bulletin emphasizes that this is a long-standing position of the California Department of Insurance. The goal is to ensure consistent and complete reporting without causing a disadvantage for those employers that do report all required injuries as compared to those that do not.

Recommendations:

In order to comply with the WCIRB's revised reporting guidelines insured employers must report all claims, including any medical costs previously paid as first aid within 5 days of knowledge[1]. In addition, physicians are required to file a Doctor's First Report of Occupational Injury or Illness with the appropriate Starr Companies third party administrator within 5 days of the first examination. We recommend reminding your designated

[1] Title 8, CCR §14001

industrial clinics of this requirement to assure compliance. This information will then be used to report the information and data necessary to California.

What is the Impact?

There are expected changes to frequency caused by the reporting of first aid claims, which may impact experience modifications used for insurance ratings. There may also be claims administration costs related to reporting claims that may not have previously been submitted. There should also be some benefit to paying medical costs pursuant to fee schedule reductions and any applicable provider network savings.

Potential Penalties:

There are potential civil penalties between $50 and $200 for a pattern or practice or willful violations for failure to file Employer's First Reports or Doctor's First Report of Occupational Injury reports as well as penalties up to $5,000 for delays in reporting cases involving serious injury or illness or death.[2]

If any additional information that impacts this communication becomes available, we will provide updates.

If you have questions contact your claims TPA (Third Party Administrator).

[2] CA Labor Code §6409.1, §6413.5

STATE OF CALIFORNIA - DEPARTMENT OF INDUSTRIAL RELATIONS
Division of Workers' Compensation

Notice to Employees--Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical o r mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, a your employer does not offer you regular, 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.You must obtaintheir agreement to treat you for your work injury.Forinstructions, 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 within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPNor HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: _____

MPN Effective Date: _____ MPN Identification number: _____

If you need help locating an MPN physician, call your MPN access assistant at: _____

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at: _____

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):

Claims Administrator GALLAGHER BASSETT SERVICES INC Phone 855-782-7750

Workers' compensation insurer Starr Indemnity & Liability Co (Enter "self-insured" if appropriate)

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

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.

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 para trabajadores incluyen:

- **Atención Médica:** Consultas médic as, 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 mas de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible 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 imp ida 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. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

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

Página web de la MPN: _____

Fecha de vigencia de la MPN: _____ Número gratuito de la MPN vigente: _____

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: _____
Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: _____

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 establecido por el estado.

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

Administrador de Reclamos GALLAGHER BASSETT SERVICES INC Teléfono 855-782-7750

Asegurador del Seguro de Compensación de trabajador Starr Indemnity & Liability Co (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Comp ensación de T rabajdores . El Oficial de Información y Asistencia más cercano se localiza en: _____
o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "ompensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de 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.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

STARR INDEMNITY & LIABILITY CO

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

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

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

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

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

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

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

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Información De Indemnización Por Accidentes Laborales De Colorado

Su empleador tiene cobertura de indemnización por accidentes laborales para empleados completamente:

STARR INDEMNITY & LIABILITY CO

La indemnización por accidentes laborales es un tipo de cobertura de seguro que los empleadores deben proveer a sus empleados. El coste del seguro de indemnización por accidentes laborales es pagado completamente por el empleador y no puede ser deducido de los sueldos de un empleado.

Si usted sufrió un accidente o mantiene una enfermedad profesional en su trabajo, usted puede calificar para los beneficios de compensación. Usted tiene la obligación de NOTIFICAR POR ESCRITO A SU EMPLEADOR DENTRO DE 4 DÍAS DEL ACCIDENTE. Si usted no informa sobre su accidente o enfermedad profesional inmediatamente sus beneficios podrían ser reducidos.

Si usted no puede trabajar por el resultado de su accidente de trabajo o la enfermedad profesional, los beneficios de compensación serán pagados sobre la base de 2/3 de su sueldo semanal hasta un máximo fijado por ley. Los primeros 3 dias no son cubiertos por la aseguranza.

Usted está autorizado para el tratamiento médico que sea razonable y necesario si usted sufrió lesiones en el trabajo o enfermedades profesionales. Si usted notifica a su empleador sobre una lesión o la enfermedad profesional y no le ofrecen atención médica adecuada, usted puede seleccionar los servicios de otro médico que tenga licencia o que sea quiropráctico.

Usted puede reportar su propio reclamo si su empleador no lo ha hecho. Para obtener formularios o información acerca de accidentes laborales usted puede puede llamar al servicio de asistencia al numero 303-318-8700 o sin costo a 1-888-390-7936 o visitar nuestro sitio web en www.colorado.gov/cdle/dwc.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
633 17th St. Suite 400, Denver, CO 80202-3660

Cualquier información proveída abajo viene directamente de su empleador y es exclusivo de este lugar del empleo:

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

ALABAMA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

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

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

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

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

Signed: _____ Date: _____

Authorized Representative of Named Insured

Named Insured: MEDSPEED, LLC

Named Insured's Mailing Address 140 INDUSTRIAL DR.
ELMHURST IL 60126

Policy Number: 100 0004019

Name and Address of Agent: CLAUDIA MANDATO
444 W 47TH ST STE 900
KANSAS CITY MO 64112

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

EMPLOYEE'S NOTICE TO REJECT TERMS OF THE ARIZONA WORKER'S COMPENSATION LAW

POLICY NO. 100 0004019 DATE 12/31/2020

To

MEDSPEED, LLC

(Full Name of Employer)

140 INDUSTRIAL DR.
ELMHURST IL 60126

(Address of Employer in Full)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

(Employee Print Name Here)	(Social Security Number of Employee)
(Address of Employee)	(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the worker's compensation insurance carrier.

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

EMPLOYEE'S NOTICE TO REJECT TERMS OF THE ARIZONA WORKER'S COMPENSATION LAW

POLICY NO. 100 0004019 DATE 12/31/2020

To

MEDSPEED, LLC

(Full Name of Employer)

140 INDUSTRIAL DR.
ELMHURST IL 60126

(Address of Employer in Full)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

(Employee Print Name Here)	(Social Security Number of Employee)
(Address of Employee)	(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the worker's compensation insurance carrier.

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF THE TERMS OF THE WORKER'S COMPENSATION LAW

POLICY NO. 100 0004019 DATE 12/31/2020

To

MEDSPEED, LLC

(Full Name of Employer)

140 INDUSTRIAL DR.
ELMHURST IL 60126

(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF THE TERMS OF THE WORKER'S COMPENSATION LAW SIGNED BY ME

ON

(Employee Print Name Here)	(Social Security Number of Employee)
(Address of Employee)	(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon employer. The employer shall, in all cases, within five days of receipt of notice, file a copy with the worker's compensation insurance carrier,

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF THE TERMS OF THE WORKER'S COMPENSATION LAW

POLICY NO. 100 0004019 DATE 12/31/2020

To

MEDSPEED, LLC

(Full Name of Employer)

140 INDUSTRIAL DR.
ELMHURST IL 60126

(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF THE TERMS OF THE WORKER'S COMPENSATION LAW SIGNED BY ME

ON

(Employee Print Name Here)		(Social Security Number of Employee)
(Address of Employee)		(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon employer. The employer shall, in all cases, within five days of receipt of notice, file a copy with the worker's compensation insurance carrier,

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

COLORADO WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

Colorado law requires that we provide a notice outlining the available deductibles for medical expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY issued by a member company of the Starr Companies. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced based on the deductible amount selected and a credit amount determined by Starr. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your Colorado operations.

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

	Deductible Amount
_____	$500
_____	$1,000
_____	$1,500
_____	$2,000
_____	$2,500
_____	$5,000
_____	$10,000
_____	$13,500
_____	$15,500

Signed: Date:

Authorized Representative
of Named Insured

Named Insured: MEDSPEED, LLC

Named Insured's Mailing Address 140 INDUSTRIAL DR.
ELMHURST IL 60126

Binder/Policy Number: 100 0004019

Name and Address of Agent: CLAUDIA MANDATO
444 W 47TH ST STE 900
KANSAS CITY MO 64112

Form WC PN CO (01-15)

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

GEORGIA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

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

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

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

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

Signed: _____ Date: _____

Authorized Representative of Named Insured

Named Insured: MEDSPEED, LLC

Named Insured's Mailing Address 140 INDUSTRIAL DR.
ELMHURST IL 60126

Policy Number: 100 0004019

Name and Address of Agent: CLAUDIA MANDATO
444 W 47TH ST STE 900
KANSAS CITY MO 64112

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

~~Effective 7-1-88~~

0.C.G.A. 34-9-2.1

(a) A corporate officer who elects to be exempt from coverage under this chapter shall make such election by giving written certification to the insurer or, if there is no insurer, to the State Board of Workers' Compensation.

(b) A corporate officer who has exempted himself by proper certification from coverage under this chapter may at any time revoke such exemption and thereby accept coverage under this chapter by giving certification to such effect in the same manner as provided in subsection (a) of this Code section relative to exemption from coverage.

(c) No certification given pursuant to subsection (a) or (b) of this Code section shall become effective until 30 days after it is filed with the proper entity.

0.C.G.A. 34-9-2.2

Any sole proprietor or partner of a business whose employees are eligible for benefits under this chapter may elect to be included as an employee under the Workers' Compensation insurance coverage of such business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner shall, upon such election be entitled to the employee benefits and be subject to the employee responsibilities prescribed in this chapter.

Address all correspondence to:

State Board of Workers' Compensation
Suite 1000-South Tower
One CNN Center
Atlanta, Georgia 30303-2788

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Effective 7-1-88

0.C.G.A. 34-9-2.1

(a) A corporate officer who elects to be exempt from coverage under this chapter shall make such election by giving written certification to the insurer or, if there is no insurer, to the State Board of Workers' Compensation.

(b) A corporate officer who has exempted himself by proper certification from coverage under this chapter may at any time revoke such exemption and thereby accept coverage under this chapter by giving certification to such effect in the same manner as provided in subsection (a) of this Code section relative to exemption from coverage.

(c) No certification given pursuant to subsection (a) or (b) of this Code section shall become effective until 30 days after it is filed with the proper entity.

0.C.G.A. 34-9-2.2

Any sole proprietor or partner of a business whose employees are eligible for benefits under this chapter may elect to be included as an employee under the Workers' Compensation insurance coverage of such business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner shall, upon such election be entitled to the employee benefits and be subject to the employee responsibilities prescribed in this chapter.

Address all correspondence to:

State Board of Workers' Compensation
Suite 1000-South Tower
One CNN Center
Atlanta, Georgia 30303-2788

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Effective 7-1-88

0.C.G.A. 34-9-2.1

(a) A corporate officer who elects to be exempt from coverage under this chapter shall make such election by giving written certification to the insurer or, if there is no insurer, to the State Board of Workers' Compensation.

(b) A corporate officer who has exempted himself by proper certification from coverage under this chapter may at any time revoke such exemption and thereby accept coverage under this chapter by giving certification to such effect in the same manner as provided in subsection (a) of this Code section relative to exemption from coverage.

(c) No certification given pursuant to subsection (a) or (b) of this Code section shall become effective until 30 days after it is filed with the proper entity.

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION
CORPORATE OFFICER REINSTATEMENT

The use of this form is required under the provisions of O.C.G.A. 34-9-2.1 of the Workers' Compensation Law if a corporate officer desires not to be exempt from coverage.

NOTICE TO REVOKE REJECTION

I _____**, certify that I am**

an officer of _____ **and elect**

to revoke the rejection of the provisions of the Georgia Workers' Compensation Law.

Dated this _____ **day of** _____**, 20** _____

Signed _____

A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER.

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NEW MEXICO WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

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

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

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

	Deductible Amount
_____	$500
_____	$1,000
_____	$1,500
_____	$2,000
_____	$2,500
_____	$5,000
_____	$10,000

Signed: _____ Date: _____

Authorized Representative of Named Insured

Named Insured: MEDSPEED, LLC

Named Insured's Mailing Address 140 INDUSTRIAL DR.
ELMHURST IL 60126

Policy Number: 100 0004019

Name and Address of Agent: CLAUDIA MANDATO
444 W 47TH ST STE 900
KANSAS CITY MO 64112

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Name & Mailing Address of the Insured:

MEDSPEED, LLC
140 INDUSTRIAL DR.
ELMHURST IL 60126

Policy Number 100 0004019

Policy Period 12/31/2020 to 12/31/2021

Endorsement Number

WARNING
$ 500 FINE

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

STARR INDEMNITY & LIABILITY COMPANY

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Dallas, TX 1-866-519-2522

TEXAS COMPLAINT NOTICE

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

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

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

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

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

TO: All State Employees -

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

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

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STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

NOTICE OF RIGHT TO FILE A COMPLAINT

Insured's Name: MEDSPEED, LLC

Policy Number:100 0004019
Policy Period: 12/31/2020 **to** 12/31/2021

Producer's Name: CLAUDIA MANDATO

Effective Date: 12/31/2020

Producer's Telephone #: 333-333-3333

Writing Company: Starr Companies

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

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WISCONSIN POLICYHOLDER INFORMATION NOTICE

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Starr Companies

8401 N. Central Expressway; 5th floor

Dallas, TX 75225

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STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

WISCONSIN POLICYHOLDER INFORMATION NOTICE

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? _____ If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problems.

Starr Companies

8401 N. Central Expressway; 5th floor

Dallas, TX 75225

You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

NOTICE OF RIGHT TO FILE A COMPLAINT

Insured's Name: MEDSPEED, LLC

Policy Number: 100 0004019
Policy Period: 12/31/2020 **to** 12/31/2021

Producer's Name: CLAUDIA MANDATO

Effective Date: 12/31/2020

Producer's Telephone #: 333-333-3333
Writing Company: Starr Companies

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P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission **Revised 10-01-2017**

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

MEDSPEED, LLC

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

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

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

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

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name STARR INDEMNITY & LIABILITY CO

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

City/Town New York **State** New York **Zip Code** 10022

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

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

Address See Attached **Telephone** _____

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

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

If your employer has listed a location below, you MUST file your compensation claim there.
When filing your claim, you are also required – by law – to send it by certified mail.

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

Employer Name _____

Address _____ **Telephone** _____

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

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

Date Posted: _____

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

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

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

District 2 — Norwich

90 Sachem Street
Norwich, CT 06360

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

District 3 — New Haven

700 State Street
New Haven, CT 06511-6500

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

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 06604

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

District 5 — Waterbury

55 West Main Street
Waterbury, CT 06702

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

District 6 — New Britain

233 Main Street
New Britain, CT 06051

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

District 7 — Stamford

111 High Ridge Road
Stamford, CT 06905

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

District 8 — Middletown

90 Court Street
Middletown, CT 06457

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

Department of Employment Services
LABOR STANDARDS BUREAU

OFFICE OF WORKERS' COMPENSATION

4058 MINNESOTA AVENUE, N.E. •WASHINGTON, DC 20019 •(202) 671-1000
•(202) 671-1929 (Fax)

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed the form, mail it to the Office of Workers' Compensation at the above address, and to your employer.
2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 or visit http://does.dc.gov for information.
3. You may not sue your employer as a result of a work-related injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.
4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within one (1) year after the last payment of benefits.
5. If you need information regarding your rights and obligations prescribed by law, you may call your employer first. If you require further information, you may call the Office of Workers' Compensation at (202) 671-1000 or visit http://does.dc.gov
6. The law gives you the right to legal representation if you so choose.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have one (1) or more employees.
2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.
3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, send a copy to the nearest claim office of your insurer, for all occupational injuries or disease, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.
5. You are required to report to the Office of Workers' Compensation, and your insurer, any disability of more than three (3) days which was not previously reported, as soon as possible, but no later than ten (10) working days after the date of knowledge thereof.
6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.
7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov.

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations.

NAME OF INSURANCE COMPANY

Address: **STARR INDEMNITY & LIABILITY CO**

399 PARK AVENUE NEW YORK, NEW YORK 10022

Phone: _____

NAME OF EMPLOYER

Address _____ Phone: _____

Employer Representative: **MEDSPEED, LLC**

364279497

Employer ID Number (if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN
AND ABOUT THE EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1 DCWC
Revised March, 2017

Departamento de Servicios de Empleo
OFICINA DE ESTÁNDARES LABORALES

OFICINA DE COMPENSACIÓN DE TRABAJADORES

4058 MINNESOTA AVENUE, N.E. •WASHINGTON, DC 20019 •(202) 671-1000
•(202) 671-1929 (Fax)

ADVERTENCIA: Es un delito proporcionar información falsa o engañosa a un asegurador con el propósito de defraudar al asegurador o a cualquier otra persona. Las penas incluyen prisión y/o multas. Además, un asegurador puede negar beneficios de compensación si la información falsa materialmente relacionada con una reclamación fue proporcionada por el solicitante.

NOTIFICACIÓN DE CUMPLIMIENTO

PARA EMPLEADOS

1. Por ley, usted debe informar rápidamente a su empleador y a la Oficina de Compensación de Trabajadores una lesión o enfermedad laboral, incluso si considera que es menor. Para ese fin, deberá usar el Formulario N°. 7 DCWC, Notificación de lesión accidental o enfermedad laboral, que podrá obtener del empleador o de la Oficina de Compensación de Trabajadores. Una vez completado y firmado el formulario, envíelo por correo a la Oficina de Compensación de Trabajadores a la dirección antes mencionada y a su empleador.
2. Usted tiene derecho, si es necesario, a los servicios de un médico u hospital de su elección y a los salarios perdidos. Llame al (202) 671-1000 o visite http://does.dc.gov para obtener información.
3. Usted no debe demandar a su empleador como resultado de una lesión o enfermedad relacionada con el trabajo debido a que la Ley de Compensación de Trabajadores es su único recurso.
4. Con el fin de preservar su derecho a los beneficios en el marco de la Ley de Compensación de Trabajadores del D.C., usted debe completar una reclamación por escrito en el Formulario N°. 7A DCWC, Solicitud de reclamación del empleado, en el término de un (1) año después de su lesión, o en el término de un (1) año después del último pago de beneficios.
5. Si necesita información sobre sus derechos y obligaciones prescritas por ley, puede llamar primero a su empleador. Si necesita más información, puede llamar a la Oficina de Compensación de Trabajadores al (202) 671-1000 o visitar http://does.dc.gov
6. La ley le concede el derecho a representación legal si elige tenerla.

PARA EMPLEADORES

1. Es obligatorio tener cobertura de seguro de Compensación de trabajadores si tiene uno (1) o más empleados.
2. Debe exhibir este cartel en cada lugar de trabajo para que sea del mayor beneficio posible para sus empleados.
3. Deberá presentar un Formulario N°. 8 DCWC, Primer informe del empleador sobre lesión o enfermedad laboral, ante la Oficina de Compensación de Trabajadores, enviar una copia a la oficina de reclamaciones de su aseguradora más cercana, por cualquier lesión o enfermedad laboral, lo antes posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
4. Su empleado debe presentar el Formulario N°. 7 DCWC, Notificación del empleado de lesión accidental o enfermedad laboral. Por favor provea a su empleado con el Formulario N°. 7 DCWC e indíquele que lo complete y se lo entregue a usted y a la Oficina de Compensación de Trabajadores. Una vez que haya recibido la notificación del empleado, deberá enviar al empleado una notificación de sus derechos y obligaciones por correo certificado, solicitando el acuse de recibo.
5. Deberá informar a la Oficina de Compensación de Trabajadores y a su aseguradora cualquier discapacidad de más de tres (3) días que no haya sido informada previamente, tan pronto como sea posible, pero a más tardar diez (10) días hábiles después de la fecha en que tenga conocimiento del hecho.
6. Deberá proporcionar o hacer que se proporcionen servicios médicos y hospitalarios razonables, otros cuidados curativos o rehabilitación vocacional y diversos tipos de compensación por discapacidad al empleado lesionado o discapacitado.
7. Deberá obtener de la aseguradora identificada a continuación un suministro de todos los Formularios de compensación de trabajadores requeridos, o puede descargar los formularios y la notificación mencionados anteriormente en nuestro sitio web http://does.dc.gov.

NOTIFICACIÓN: La violación de las diversas disposiciones de la ley de Compensación de Trabajadores prevé sanciones civiles.

El empleador abajo firmante notifica por la presente el cumplimiento de todas las disposiciones de la Ley de Compensación de Trabajadores y las Normas Administrativas.

NOMBRE DE LA EMPRESA ASEGURADORA

Dirección: **STARR INDEMNITY & LIABILITY CO**

399 PARK AVENUE NEW YORK, NEW YORK 10022

Teléfono: _____

NOMBRE DEL EMPLEADOR

Dirección: _____ Teléfono: _____

Representante del Empleador: **MEDSPEED, LLC**

364279497

Número de identificación del empleador (si el número es desconocido, el empleador debe solicitarlo al IRS)

ESTE AVISO SE PUBLICARÁ NOTORIAMENTE EN
Y SOBRE LOS LUGARES DE NEGOCIO DEL EMPLEADOR

TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

MEDSPEED, LLC

Employer

Date

By _____
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

PARA EL PATRON: ESTE AVISO DEBE SER PUESTO EN UN LUGAR CONSPICUO EN SU SITIO DE NEGOCIO.

AVISO

RESPECTO A EL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADÓS POR EL SUSCRITO SON, POR LA PRESENTE, NOTIFICADOS QUE EL PATRON HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTES, DE ACUERDO CON LAS PROVISIONES DE LA LEY DE COMPENSACIÓN PARA TRABAJADORES.

MEDSPEED, LLC

Patrón

Fecha

Por

Agente Autorizado del Patron

Un empleado que recibe un daño en un accidente tiene que notificar immediatamente a su mayordomo o mayordoma, superintendente o a la persona suscrita, quien proveera atencion médica.

Reclamación para compensación tiene que ser hecha por escrito y entregada al patrón. Formas explicando el daño y reclamando compensación serán proveidas por el patron; pór el fiador,

o con solicitud, por La Comisión Industrial en Boise, Idaho.

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	GALLAGHER BASSETT SERVICES INC		
Business address	2915 Premiere Parkway, ST 350 Duluth GA 30097-5241		
Business phone	855-782-7750		
Effective date	12/31/2020	Termination date	12/31/2021
Policy number	100 0004019	Employer's FEIN	364279497

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

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

WORKERS' COMPENSATION

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Web site: www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Deaf):	312/814-2959

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COMPENSACION A LOS TRABAJADORES

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

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

1. OBTENGA AYUDA MEDICA. Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los sintomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.

2. NOTIFIQUE A SU EMPLEADOR. Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.

3. CONOZCA SUS DERECHOS. Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

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

Es contra la ley que el empleador moleste, despida o se niegue a reemplear o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.

4. MANTENGASE DENTRO DEL LIMITE DE TIEMPO. Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del ultimo pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

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

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Web site:	www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Sordo):	312/814-2959

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

Nombre:	GALLAGHER BASSETT SERVICES INC		
Dirección de la Compañía:	2915 Premiere Parkway, ST 350 Duluth GA 30097-5241		
Teléfono de la Compañía:	855-782-7750		
Fecha efectiva:	12/31/2020	Fecha de terminación:	12/31/2021
Número de Póliza:	100 0004019	FEIN del Empleador:	364279497

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

COMPENSACION A LOS TRABAJADORES

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

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WORKER'S COMPENSATION NOTICE

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

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

The worker's compensation insurance carrier or the administrator for

MEDSPEED, LLC (name of company) **is:** **GALLAGHER BASSETT SERVICES INC** (name of insurance carrier or administrator)

GALLAGHER BASSETT SERVICES INC
(name of carrier/administrator)

2915 Premiere Parkway, ST 350
(mailing address)

Duluth GA 30097-5241
(city, state, zip)

855-782-7750
(telephone number)

(contact person)

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

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

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

La compañía de seguro de compensación del trabajador o el administrador de la compañía MEDSPEED, LLC es:
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GALLAGHER BASSETT SERVICES INC
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2915 Premiere Parkway, ST 350
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Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE
NEW YORK, NEW YORK 10022

Phone number 646-227-6563

DEPARTMENT OF LABOR AND INDUSTRY

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

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

August 2017

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Compensación laboral

Si usted se lesiona

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

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

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

compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

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

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

Fraude

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

Nombre e información de contacto de la compañía aseguradora

STARR INDEMNITY & LIABILITY CO

399 PARK AVENUE
NEW YORK, NEW YORK 10022

Número de teléfono 646-227-6563

DEPARTAMENTO DE TRABAJO E INDUSTRIA

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

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Agosto de 2017

Compensación laboral

Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podria perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada,(CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
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Agosto de 2017

DIVISION OF WORKERS' COMPENSATION

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

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

Name STARR INDEMNITY & LIABILITY CO

Address 399 PARK AVENUE

NEW YORK, NEW YORK 10022

Phone 646-227-6563

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 accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____, _____.
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

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

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and 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 a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:
For information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

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

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

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

Steps to Take When an Injury Occurs

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

Workers' Safety

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

Fraud/Noncompliance

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

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

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

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

WC-106 (07-19) AI

DIVISION OF WORKERS' COMPENSATION

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

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

Name STARR INDEMNITY & LIABILITY CO

Address 399 PARK AVENUE

NEW YORK, NEW YORK 10022

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WC-106 (07-19) AI

DIVISION OF WORKERS' COMPENSATION

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

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

Nombre STARR INDEMNITY & LIABILITY CO

Dirección 399 PARK AVENUE
NEW YORK, NEW YORK 10022

Teléfono 646-227-6563

Información del empleado

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

Pasos a seguir si se lesiona en el trabajo

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

_____, _____.
representante del empleador *número de teléfono*

No hacerlo puede poner en peligro su capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**
3. Obtenga más información de los beneficios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita.

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

Beneficios para trabajadores lesionados

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

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

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

Beneficios de sobreviviente:

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

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

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

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

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

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

Pasos a tomar cuando ocurre una lesión

1. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un ~~Informe primero de lesión~~ con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.
3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derecho a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)
4. Para obtener más información sobre la responsabilidad o el seguro relacionados con el Programa de compensación al trabajador, viste www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

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

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

Fraude/no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E, castigado con una multa de hasta $10,000, o el doble de la cantidad del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

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

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

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

DIVISION OF WORKERS' COMPENSATION

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

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

Nombre STARR INDEMNITY & LIABILITY CO

Dirección 399 PARK AVENUE
NEW YORK, NEW YORK 10022

Teléfono 646-227-6563

Información del empleado

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

Pasos a seguir si se lesiona en el trabajo

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

_____, _____.
representante del empleador *número de teléfono*

No hacerlo puede poner en peligro su capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**
3. Obtenga más información de los beneficios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita.

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

Beneficios para trabajadores lesionados

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

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

Beneficios de sobreviviente:

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

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Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

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Pasos a tomar cuando ocurre una lesión

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Fraude/no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E, castigado con una multa de hasta $10,000, o el doble de la cantidad del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

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

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

POSTING NOTICE

The law requires every insured employer to post and maintain notices naming the company insuring its compensation liability "in a conspicuous place or places in and about the employer's place of business." The form of notice is prescribed by the Commissioner of Insurance and shall be clearly printed on a minimum of 90# index, 8½" by 11" in size. The content and arrangement of items must be consistent with the layout shown below. In accordance with 3:2-1 a duplicate filing must be made before the form is placed in use.

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

(STARR INDEMNITY & LIABILITY CO) Insurance Company

for the period

Beginning 12/31/2020 . . . . . Ending 12/31/2021 . . . . . .

Employer .MEDSPEED, LLC . . . . . .

. . . . . .

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

Form 17 NJ

AVISO

El patron avisa que ha asegurado el pago de compensación a los empleados y sus dependientes, de acuerdo con lo provisto por la ley de responsabilidad de los patrones de seguro para sus empleados. Titulo 34, Capitulo 15, Articulo 5, revision de estatutos del Estado de New Jersey, asegurandolos con.

(STARR INDEMNITY & LIABILITY CO) Compañia de Seguro

por el periodo

Comenzando **12/31/2020** . . . . . .Terminando **12/31/2021** . . . . . .

Patron **MEDSPEED, LLC** . . . . . .
. . . . . .

De acuerdo con la ley mencionada arriba, esta noticia debe ser colocada y mantenida en un lugar visible en todos los lugares de trabajo.

Form 17NJ

O

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, _____, was involved in an on-the-job accident or was disabled
Yo, (name of employee*/nombre del empleado)* *me lastimé en un accidente en el trabajo o fui incapacitado*

by an occupational disease at approximately _____, on _____, 20 ____.
por enfermedad de oficio aproximadamente (time*/a la(s) hora(s))* *el* (date*/fecha)* *del 20* ____.

Employee's social security number: _____ Where did the accident occur? _____
Número de seguro social del empleado: *¿Dónde ocurrió el accidente?*

What happened? _____
¿Qué ocurrió?

_____

_____

To be completed by Employer:
Completado por el empleador:
If Yes, Employer has right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.

Worker will choose health care provider. Yes___ No___
Trabajador elegirá proveedor de atención médica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.

WORKER MUST INITIAL _____ *INICIALES DEL TRABAJADOR*

Signed: _____ Signed/Notice Received: _____
Firma: (employee*/empleado*) *Firma/Notificación recibida:* (employer or representative*/empleador o representante)*
Date/Fecha: _____ Date/*Fecha*: _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Worker --
For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador
Para emergencias médicas vaya a cualquier clinica / hospital.

Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de dias festivos.

Statewide Helpline -- *Linea de Asistencia*

1-866-WORKOMP / 1-866-967-5667

toll free -- *llamada sin costo de larga distancia*

New Mexico Workers' Compensation Administration
PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043

www.workerscomp.state.nm.us

Employer/employee: Each keep one copy.
Empleador/empleado: Retener una copia.

Form NOA-1-W (4/12)

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

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

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

For Insurance Carriers ONLY: Policy No. 100 0004019

Policy in Force from 12/31/2020 *to* 12/31/2021

Name of employer (Nombre del patrono)
MEDSPEED, LLC

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

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

FORM 17 Revised 10/2017

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

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

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

The Employee Should:

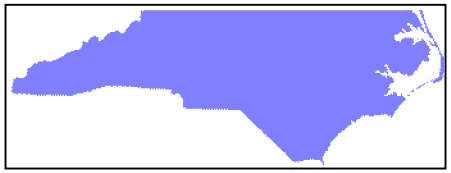
- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's compensation insurance carrier is Starr Indemnity & Liability Company.
- The insurance policy number is 100 0004019.
- Your employer's workers' compensation insurance policy is valid from 12/31/2020 until 12/31/2021.

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
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

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

FORMA 17 Revisada 11/2017

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

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 excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

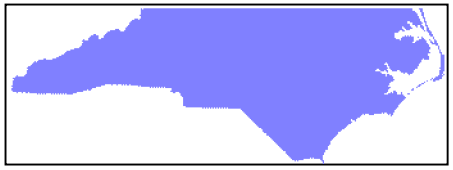
- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional..**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia.**
- **Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es** Starr Indemnity & Liability Company.
- **El número de la póliza de seguro es** 100 0004019.
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde** 12/31/2020 hasta 12/31/2021.

Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA—(800) 688-8349.

El Empleador deberá:

- **Proveer todos los servicios médicos necesarios al empleado.**
- **Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $2,000.00.**
- **Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.**
- **Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.**

Para asistencia con entrenamiento de seguridad:
Director de Entrenamiento de Seguridad—(919) 807-2602 y safety@ic.nc.gov.



NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240

Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen. Stat. § 97-93).

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION

REMEMBER: IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: MEDSPEED, LLC

Date Posted:

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company: STARR INDEMNITY & LIABILITY CO

Address: NEW YORK, NEW YORK 10022
399 PARK AVENUE

Telephone Number: (646)227-6563

Insurer's Code: 2429

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

Name of TPA (Claims administrator): GALLAGHER BASSETT SERVICES INC

Address: 2915 Premiere Parkway, ST 350
Duluth GA 30097-5241

Telephone Number: 855-782-7750

IF SELF-INSURED
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number:

Insurer Code:

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

Name of TPA (Claims administrator):

Address:

Telephone Number:

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A §4117 (relating to insurance fraud).

Employer Information Services	Claims Information Services	Hearing Impaired	Email
717.772.3702	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-li-bwc-helpline@pa.gov

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

SAFETY

AVOID THE WORST

BE PART OF THE
SAFETY TEAM

TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

_____

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

_____

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

_____

***Telephone number** of employer representative to notify in event of a work-related injury*

_____

***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4812 *TTD: 800-332-2257*

tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

LB-0922 (REV. 4/18) Authorization No. 337545 RDA 10183

TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

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LB-0922 (REV. 4/18) Authorization No. 337545 RDA 10183

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia.
   En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.

Nombre en letra de molde y título *del representante del empleador a ser notificado en caso de una lesión laboral*

Nombre en letra de molde del ***representante del empleador alterno*** *a ser notificado en caso de una lesión laboral*

Número de teléfono *del representante del empleador a ser notificado en caso de una lesión laboral*

Dirección *del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

BWC Bureau of WORKERS' COMPENSATION

220 French Landing Dr. 1-B
Nashville, TN 37243-2667
800-332-2667
615-532-4810 *TTD: 800-332-2257*
tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

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NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: MEDSPEED, LLC has workers' compensation insurance coverage from STARR INDEMNITY & LIABILITY CO. In the event of work-related injury or occupational disease. This coverage is effective from 12/31/2020. Any injuries or occupational diseases which occur on or after that date will be handled by STARR INDEMNITY & LIABILITY CO. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

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

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

COVERED EMPLOYER

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

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

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

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

Do Not Post This Side

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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: MEDSPEED, LLC has workers' compensation insurance coverage from STARR INDEMNITY & LIABILITY CO. In the event of work-related injury or occupational disease. This coverage is effective from 12/31/2020. Any injuries or occupational diseases which occur on or after that date will be handled by STARR INDEMNITY & LIABILITY CO. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

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

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

COVERED EMPLOYER

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

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

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

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

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: MEDSPEED, LLC
STARR INDEMNITY & LIABILITY CO tiene cobertura de seguros de compensación para trabajadores con STARR INDEMNITY & LIABILITY CO para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde 12/31/2020. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

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

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

EMPLEADOR CON COBERTURA

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

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

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

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

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: MEDSPEED, LLC STARR INDEMNITY & LIABILITY CO tiene cobertura de seguros de compensación para trabajadores con STARR INDEMNITY & LIABILITY CO para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde 12/31/2020. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

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

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EMPLEADOR CON COBERTURA

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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;
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4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

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AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

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EMPLEADOR CON COBERTURA

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NO MOSTRAR ESTE LADO

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

Call the Division of Workers' Compensation at 1-800-252-7031 or access the division's website at www.tdi.texas.gov/wc/indexwc.html to receive information on the legal requirement for coverage, to verify whether your employer has provided the required coverage, or to report an employer's failure to provide coverage.

TO THE EMPLOYER/CONTRACTOR:

Pursuant to Workers' Compensation Rule 110.110 (d)(7), a contractor engaged in a building or construction project for a government entity is required to post a notice on each project site informing all persons providing services on the project that they are required to be covered by workers' compensation insurance. The notice required by this does not satisfy other posting requirements imposed by the Texas Workers' Compensation Act or other Workers' Compensation Rules. This notice must:

(1) be posted in English, Spanish and any other language common to the employer's employee population;
(2) be displayed on each project site;
(3) state how a person may verify current coverage and report failure to provide coverage;
(4) be printed with a title in at least 30-point bold type and text in at least 19-point normal type; and
(5) contain the exact words as prescribed in Rule 110.110 (d)(7).

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Act and Workers' Compensation Rules. The violator may be subject to administrative penalties.

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The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

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TO THE EMPLOYER/CONTRACTOR:

Pursuant to Workers' Compensation Rule 110.110 (d)(7), a contractor engaged in a building or construction project for a government entity is required to post a notice on each project site informing all persons providing services on the project that they are required to be covered by workers' compensation insurance. The notice required by this does not satisfy other posting requirements imposed by the Texas Workers' Compensation Act or other Workers' Compensation Rules. This notice must:

(1) be posted in English, Spanish and any other language common to the employer's employee population;
(2) be displayed on each project site;
(3) state how a person may verify current coverage and report failure to provide coverage;
(4) be printed with a title in at least 30-point bold type and text in at least 19-point normal type; and
(5) contain the exact words as prescribed in Rule 110.110 (d)(7).

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Act and Workers' Compensation Rules. The violator may be subject to administrative penalties.

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

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COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

La ley requiere que cada persona que trabaja en este lugar o que proporciona servicios relacionados con este proyecto de construcción debe estar cubierta por un seguro de compensación para trabajadores. Esto incluye a personas que proporcionan, transportan, o entregan equipo o materiales, o que proporcionan mano de obra, transporte u otros servicios relacionados con este proyecto, sin importar la identidad del empleador o el estado como empleado.

Llame a la División de Compensación para Trabajadores (Division of Workers' Compensation, por su nombre en inglés) al 1-800-252-7031 o visite el sitio Web de la División en www.tdi.texas.gov/wc/indexwc.html para recibir información referente al requisito legal de cobertura, así como para verificar si su empleador ha proporcionado la cobertura requerida, o para reportar a un empleador que no proporciona cobertura.

AL EMPLEADOR/CONTRATISTA:

Según lo dispuesto en el Reglamento de Compensación para Trabajadores 110.110 (d)(7), es requerido que un contratista que esté involucrado en el proyecto de construcción de un edificio de entidad gubernamental muestre este aviso en cada lugar donde se lleva a cabo el proyecto para informarles a todas las personas que proporcionan servicios en el proyecto, que es requerido que se les proporcione un seguro de compensación para trabajadores. El aviso presentado aquí no satisface los requisitos para poner a la vista otros avisos que han sido impuestos por la Ley de Compensación para Trabajadores de Texas u otros Reglamentos de Compensación para Trabajadores. Este aviso debe:

(1) ser puesto a la vista en inglés, español y cualquier otro idioma común para la población de los empleados del empleador
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Form VWC1

WORKERS' COMPENSATION NOTICE

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

THE EMPLOYEE SHOULD:

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

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

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

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

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

THE EMPLOYER SHOULD:

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

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

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

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

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

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

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

NOTICIA SOBRE COMPENSACIÓN LABORAL

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

EL EMPLEADO DEBE:

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

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

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

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

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

EL EMPLEADOR DEBE:

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

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

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

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

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

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

NOTIFICATION OF AVAILABLE LOSS CONTROL CONSULTATION SERVICES
CALIFORNIA WORKERS COMPENSATION

Starr maintains and provides Loss Control Services as required by California law. These services may be provided to our insured workers compensation policyholder places of employment. Starr is committed to helping our workers compensation policyholders provide for safe and healthy workplaces for their California employees through the provision of loss control services appropriate to the individual business.

Available services that may be provided if requested include:

- A workplace survey to identify safety and health hazards and their control.
- A review of workers compensation injury records to identify accident trends and their causes.
- Assistance in the development of your loss control management plan to minimize workplace injuries.

This includes a review of your 8 CCR, Sec. 3203 employer's Injury and Illness Prevention Program (IIPP). As appropriate, written findings and recommendations will be made that address uncontrolled hazards and program deficiencies including your employer's Injury and Illness Prevention Program. The above services are available at no additional charge to Starr workers compensation policyholders for their covered California employees.

To request such services, please contact **1-855-656-6365** or write to:

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

IMPORTANT: When leaving a message please provide your name, phone number, company name and the nature of your request.

Workers' compensation insurance policyholders may direct questions or complaints about the insurers loss control consultation services by contacting: State of California, Department of Industrial Relations, Loss Control Services Coordinator, The Commission on Health, Safety & Workers' Compensation, 455 Golden Gate Avenue, 10th Floor, San Francisco, CA 94102, phone (415) 703-4220.

FLORIDA NOTICE OF RISK MANAGEMENT PROGRAM AVAILABILITY

Florida regulations require us to develop and make available for use by our clients a Risk Management Guide. We are pleased to present to you Starr's Risk Management Guide, which includes measures, services and plans we have developed. The scope of your Risk Management Program should include the following:

1. Safety measures, including, as applicable, the following areas:

    a. Pollution and environmental hazards;
    b. Disease hazards;
    c. Accidental occurrences;
    d. Fire hazards and fire prevention and detection;
    e. Liability for acts from the course of business;
    f. Slip and fall hazards;
    g. Products injury; and
    h. Hazards unique to a particular class or category of policyholders.

2. Training to policyholders in safety management techniques.

3. Safety management counseling services.

Our guide and services are available upon request to assist in your risk management efforts. If you would like to further discuss these services, please contact us at **1-855-656-6365** or at LC.Staterequest@starrcompanies.com. You may also write to us at the following address:

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

If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, policy number and a brief description of the loss control services being requested.

FLORIDA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE

Florida law requires that we provide a notice outlining the availability of a state-authorized $2,500 deductible plan for medical and indemnity expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY.

There is no premium credit associated with this option, but any amounts paid by the employer shall not apply to the experience rating of such employer.

MINNESOTA SAFETY PROGRAM NOTICE

In accordance with Minnesota Statute §79.085, we are advising you of your right under this section to obtain certain safety and occupational health loss consultation services.

Upon your request, we will provide services to you including surveys to identify health and safety problems, review of employer injury records with appropriate personnel, and development of plans to improve employer occupational health and safety loss records.

For more information regarding these services, please contact **1-855-656-6365** or write to:

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

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

NOTIFICATION OF AVAILABLE LOSS CONTROL SERVICES
MISSOURI WORKERS' COMPENSATION POLICYHOLDERS

You are hereby notified that loss control services are available, upon request, to workers' compensation policyholders with employees working in Missouri. The services are intended to provide employers with appropriate resources to address workplace safety and health issues and reduce insured losses through a safety engineering and management program. This notice is provided pursuant to the requirements of Missouri Law. If you would like more information please contact us at **1-855-656-6365** or write to:

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

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

The Missouri Division of Workers' Compensation offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goal is to help employers control workers' compensation costs. The Division also certifies Missouri insurance carriers' safety engineering and management programs that are available to insured's upon request.

Employers may contact MWSP at 1(800)775-COMP or 573-526-3504, email mowsp@dolir.mo.gov for more information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

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

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

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

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

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

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

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

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

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

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

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

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

SOUTH DAKOTA POLICYHOLDER NOTICE

NOTICE OF ACCIDENT PREVENTION CONSULTING SERVICES

Starr is required by law to provide its policyholders with certain accident prevention services as required by South Dakota Insurance Code: § 58-21-20 at no additional cost. If you would like more information call: 1-855-656-6365.

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

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

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

IMPORTANT NOTICE TO TEXAS POLICYHOLDERS

ACCIDENT PREVENTION SERVICES

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

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

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

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

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

PRIVACY POLICY AND PRACTICES

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

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

Starr Companies Privacy Policy

~~The Personal Information We Collect~~

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

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

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

The Personal Information We Share

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

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

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

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

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

Confidentiality and Security of Personal Information

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

Changes in Privacy Policy

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

How to Contact Us

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

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

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

IMPORTANT NOTICE TO POLICYHOLDER
FLORIDA

To present inquiries about coverage and/or to obtain assistance in resolving any complaints:

You may call Starr's toll-free telephone number at:

1-866-519-2522

You may also write the company at:

Starr Indemnity & Liability Company
Attn: Legal Department
399 Park Avenue, 8th Floor
New York, NY 10022

You may contact the Florida Office of Insurance Regulation at:

200 East Gaines Street
Tallahassee, FL 32399
Web Address: www.floir.com
Phone: 877-693-5236 (In-State)
850-413-3089 (Out-of State)

Starr Indemnity & Liability Company

Dallas, Texas
Administrative Office: 399 Park Avenue, 8th Floor, New York, NY 10022

Workers Compensation Policy Jacket

Named Insured: **MEDSPEED, LLC**

Policy Number: **100 0004019**

Effective Date: **12/31/2020 at 12:01 A.M.**

This Policy is a legal contract between the Named Insured and Starr, a Stock Company, (herein referenced as "the Company"). The Company agrees to provide insurance to the Named Insured, in exchange for the payment of the required premium. Coverage is subject to the terms and conditions described in this Policy.

This Policy and the coverage provided by it become effective at 12:01 A.M. at the address of the Named Insured on the Policy Effective Date shown above. It continues in effect in accordance with the provisions set forth in this Policy.

This Policy is governed by the laws of the state where it was delivered.

IN WITNESS WHEREOF, we have cause this Policy to be signed and countersigned where required by law on the Declarations by our duly Authorized representative.

President &CEO

General Counsel

MEDSPEED, LLC
140 INDUSTRIAL DR.
ELMHURST IL 60126

MARYLAND CONSTRUCTION CLASSIFICATION PREMIUM REDUCTION PROGRAM (CCPRP)
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

The Maryland Construction Classification Premium Reduction Program (Program) is applicable to qualifying employers engaged in contracting operations. In order to qualify for the Program, a policy must have more than 50% of manual premium attributable to one or more contracting classifications (as designated by the Program) and be experience rated.

A special premium calculation, which may result in a premium credit for you, will be based on hourly pay rates for each classification of contracting operations. In order that your premium may be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to:

NCCI
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, Florida 33487-1362
ATTN: EXPERIENCE RATING—MD

NCCI will advise us of any premium credit applicable.

If NCCI does not receive this application within 180 days after policy inception or receipt of notification, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state of Maryland, report the total Maryland payroll. (Exclude overtime premium pay, vacation pay, unanticipated bonuses, and Davis Bacon fringe benefits you pay into any ERISA qualified third party pension plan, as well as the entire pay for any exempt sole proprietor, partner, or officer.) Also report the corresponding total number of hours worked for the third calendar quarter (July, August, September) of the year preceding your policy effective date as reported to taxing authorities.

Note #1: If you did not engage in contracting operations during the third calendar quarter, provide the requested information for the last complete calendar quarter prior to the policy effective date of your workers compensation policy.

Note #2: If you are a new business (no prior operations), submit the requested information for the first complete calendar quarter following the policy effective date of your workers compensation policy when available.

Note #3: In the absence of specific records for salaried employees, you should assume that each individual worked 40 hours per week. Payroll for partners, sole proprietors, and corporate officers subject to contracting classifications will be allocated according to appropriate ***Basic Manual*** minimum and maximum payroll limitations.

You must preserve your payroll records, which formed the basis for this declaration, because we are required to verify the reported information before applying for any premium credit.

Thank you for your cooperation.

Sincerely,

TURN PAGE OVER FOR PREMIUM CREDIT APPLICATION

CONTRACTING CLASSIFICATION—PREMIUM CREDIT APPLICATION

INSURED: MEDSPEED, LLC

STATE CREDIT BEING APPLIED FOR
(NOTE: one state per application):

POLICY NUMBER: 100 0004019

POLICY EFFECTIVE DATE: 12/31/2020

CARRIER:

NOTE: Unless Code(s), total wages paid, total hours worked, calendar quarter reported are indicated and application is signed and dated, it cannot be processed. Contact your agent or carrier if assistance is desired.

CLASSIFICATION	CODE	TOTAL WAGES PAID	TOTAL HOURS WORKED
Example: Electrical Wiring	5190	$8,000	520
Noncontracting Classifications:			

The foregoing is based on actual wages (excluding overtime premium pay, pay in excess of payroll amount charged to partners and sole proprietors as shown on the state loss costs pages, as well as the entire pay for any exempt sole proprietor, partner, or officer) **and hours worked as reflected in our payroll records for the complete calendar quarter.**

COMPLETE CALENDAR QUARTER (please circle one):

1st (1/1-3/31)	**2nd (4/1-6/30)**
3rd (7/1-9/30)	**4th (10/1-12/31)**

CALENDAR YEAR:

SIGNATURE : **POSITION:** **DATE:**

This application must be completed and signed or it will not be processed.

"Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

MEDSPEED, LLC
140 INDUSTRIAL DR.
ELMHURST IL 60126

MISSOURI CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

The Contracting Classification Premium Adjustment Program is applicable to qualifying employers engaged in contracting operations. A premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. To determine a possible credit, please return the completed premium credit application, as set out on the reverse side of this letter, to:

NCCI, Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

NCCI will advise us of any premium credit applicable.

If NCCI does not receive this application within 180 days after policy effective date, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state of Missouri, report the total payroll (excluding overtime pay), and the corresponding total number of hours worked for any calendar quarter (first, second, third, or fourth) of the year preceding the policy effective date as reported to taxing authorities.

Note #1: You must clearly indicate the calendar quarter that is being submitted.

Note #2: If you are a new business with no prior operations or there was no complete quarter of operations prior to the policy effective date, submit the requested information for the first complete calendar quarter following the effective date of your workers compensation policy when available.

Note #3: In the absence of specific records for salaried employees, you should assume that each individual worked forty (40) hours per week.

Please preserve your payroll records that formed the basis for this declaration, because we will be required to verify the reported information in order for any premium credit to be applied.

Thank you for your cooperation.

Sincerely,

CONTRACTING CLASSIFICATION—PREMIUM CREDIT APPLICATION

Insured: MEDSPEED, LLC

POLICY NUMBER: 100 0004019 **POLICY EFFECTIVE DATE:** 12/31/2020

CARRIER: Starr Indemnity & Liability Co

NOTE: Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and application is signed, it cannot be processed. Contact your agent or carrier for assistance.

CLASSIFICATION	CODE	TOTAL WAGES PAID	TOTAL HOURS WORKED
Example: Electrical Wiring	***5190***	***$8,000***	***520***
Noncontracting Classifications:			

The foregoing is based on actual wages (excluding overtime pay) **and hours worked as reflected in our payroll records for the complete calendar quarter.**

Complete Calendar Quarter (please circle one):

1st (1/1–3/31)	**2nd (4/1–6/30)**
3rd (7/1–9/30)	**4th (10/1–12/31)**

Calendar Year: _____

SIGNATURE: _____ **POSITION:** _____ **DATE:** _____

NEW JERSEY
NOTICE OF ELECTION - PROPRIETORS AND PARTNERS
WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

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

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

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

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

NAME OF BUSINESS _____

COVERAGE IS ELECTED ____ **COVERAGE IS REJECTED** ____ **BUSINESS IS A CORPORATION OR OTHER FORM OF ORGANIZATION** ____

Always complete this section

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

Complete this section only when coverage is elected

Signature: _____ Date: _____
Proprietor or a Partner

Always complete this section

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone No.: ( ) _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and that the facts stated in it are true.

Employer Name	Date	Officer/Owner Signature*

Title

* Application must be signed by an officer or owner.

FLORIDA NOTICE OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015

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 B) 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 2015 (TRIPRA 2015), 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 2015, in whole or in part, TRIPRA 2015 is scheduled to expire on December 31, 2020.

Since the timetable for any further Congressional action regarding TRIPRA 2015 is presently unknown, and exposure to acts of terrorism remains, we are providing policyholders with relevant information concerning their workers compensation policies in the event of the TRIPRA 2015's expiration.

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.

The premium charge for the coverage that your policy provides for terrorism losses is shown in Item 4 of the policy Information Page or the Florida Terrorism Risk Insurance Program Reauthorization Act Endorsement (WC 09 04 03 B) Schedule that is attached to your policy. This amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2020, in the event of TRIPRA 2015's expiration, subject to regulatory review in accordance with applicable state law.

You need not do anything further at this time.

DEDUCTIBLE NOTICE OF ELECTION

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

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

If a deductible amount is desired, please indicate below.

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

1. $_____ per accident

2. $_____ per claim

3. $_____ medical only

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

(monthly, quarterly or other)

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

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

_____

The deductible plans have been explained to me.

_____ _____

Signature and Title Date

_____ _____

Employer Name (print or type) Address

_____ _____ _____

Insurance Company Policy No. Effective Date

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

IMPORTANT NOTICE TO POLICYHOLDERS

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

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

PLEASE READ THIS NOTICE CAREFULLY.

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

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

Steve Blakey

Steve Blakey, President

Nehemiah E. Ginsburg

Nehemiah E. Ginsburg, General Counsel

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us - Starr Indemnity & Liability Company

(1) General questions regarding your policy should be directed to:

Starr Indemnity & Liability Company
One International Place,13th Floor
Boston, MA, 02110

(2) **Dividend Calculation.** If this is a participating policy (a policy on which a dividend may be paid), upon payment or non-payment of a dividend, we shall provide a written explanation to you that sets forth the basis of the dividend calculation. The explanation will be in clear, understandable language and will express the dividend as a dollar amount and as a percentage of the earned premium for the policy year on which the dividend is calculated.

(3) **Claims Information.** Pursuant to Sections 3761 and 3762 of the California Labor Code, you are entitled to receive information in our claim files that affects your premium. Copies of documents will be supplied at your expense during reasonable business hours.

For claims covered under this policy, we will estimate the ultimate cost of unsettled claims for statistical purposes eighteen months after the policy becomes effective and will report those estimates to the Workers' Compensation Insurance Rating Bureau of California (WCIRB) no later than twenty months after the policy becomes effective. The cost of any settled claims will also be reported at that time. At twelve-month intervals thereafter, we will update and report to the WCIRB the estimated cost of any unsettled claims and the actual final cost of any claims settled in the interim. The amounts we report will be used by the WCIRB to compute your experience modification if you are eligible for experience rating.

B. Information Available from the Workers' Compensation Insurance Rating Bureau of California

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan-1995* (USRP) and the *California Workers' Compensation Experience Rating Plan-1995* (ERP). WCIRB contact information is: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service; 888.229.2472 (phone); 415.778.7272 (fax); and customerservice@wcirb.com (email). The regulations contained in the USRP and ERP are available for public viewing through the WCIRB's website at wcirb.com.

(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, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

(3) **Experience Rating Form.** Each experience rated risk may receive a single copy of its current Experience Rating Form/Worksheet free of charge by completing a Policyholder Experience Rating Worksheet Request Form on the WCIRB's website at wcirb.com/ratesheet. The Experience Rating Form/Worksheet 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:
Starr Indemnity & Liability Company, One International Place, 13th Floor, Boston, MA, 02110.

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 7 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB,1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service. Customer Service can be reached at 888.229.2472 (phone), 415.778.7272 (fax) and customerservice@wcirb.com (email).

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, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).

C. California Department of Insurance – Appeals to the Insurance Commissioner. After you follow the appropriate dispute resolution process described above, if (1) we or the WCIRB decline to review your request, (2) you are dissatisfied with the decision upon review, or (3) 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
1901 Harrison Street, 3rd Floor
Oakland, CA 94612
415.538.4243

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, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159 (phone), 415.371.5288 (fax) and ombudsman@wcirb.com (email).

B. California Department of Insurance - Information and Assistance. Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 800.927.HELP (4357) or insurance.ca.gov. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

This notice does not change the policy to which it is attached.

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws.

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.
2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or might create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.
3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per $100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.
4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.
5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.
6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.
7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.

2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.

5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.

   (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code Section 11750.3(c).

   (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

This notice does not change the policy to which it is attached.

NOTICE REQUIRED BY LAW – CALIFORNIA

Since our offer to renew your coverage reflects a premium rate increase of 25 percent or more in your governing classification, California law (Insurance Code section 11664) requires us to send you a "notice of nonrenewal", even though we do intend to renew your policy. This constitutes the required notice. 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.

Insured MEDSPEED, LLC Date of Notice 12/31/2020

Policy No. 100 0004019 Policy Period 12/31/2020 to 12/31/2021

POLICY HOLDER 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.

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 is contingent on verifying that the employee's hourly wage equals or exceeds the specified wage threshold. The determination of the regular hourly wage for any non-salaried employee must be supported by one of the following sources:

- Original time cards or time book entries for each employee. Original records must include the operations performed, the total hours worked each day and the times the employee started and ended each work period throughout the workday. At job locations where all of the employer's operations cease for a uniform unpaid meal period, recording the start and stop times of the uniform break period is not required.
- A valid collective bargaining agreement that shows the regular hourly wage rate by job classification of a worker. If using a collective bargaining agreement, the records must include an employee roster by job classification that permits the reconciliation of individual employees to the job classifications set forth in the collective bargaining agreement.

The non-salaried employee's regular hourly wage shall be determined by dividing that employee's total remuneration by the hours worked during the pay period, 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 the records specified above are not maintained and/or made available 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 has an effective date on or after January 1, 2020 and produces a final premium of $10,500 or more, a physical audit is required at least once a year; if it produces a final premium of less than $10,500 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. 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. See California Insurance Code Section 11665(a) for additional requirements regarding the audit of C-39 license holders.

POLICYHOLDER NOTICE

CALIFORNIA ASSEMBLY BILL NO. 5, INDEPENDENT CONTRACTORS

Summary of Assembly Bill No. 5 (AB 5)

For the purposes of wages, workers' compensation and other benefits, AB 5 creates a presumption that an entity's workers are employees unless the hiring entity can show that the worker meets three conditions, known as the "ABC Test". With respect to workers' compensation, AB 5 goes into effect on **July 1, 2020** and applies to policies issued on or after **July 1, 2020**, as well as policies in force as of **July 1, 2020**.

The bill adds Section 2750.3 to the California Labor Code, which provides in pertinent part:

> **2750.3.**
> (a)(1) For purposes of the provisions of this code and the Unemployment Insurance Code, and for the wage orders of the Industrial Welfare Commission, a person providing labor or services for remuneration shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates that all of the following conditions are satisfied:
>
> > (A) The person is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact.
> >
> > (B) The person performs work that is outside the usual course of the hiring entity's business.
> >
> > (C) The person is customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed.
>
> (2) Notwithstanding paragraph (1), any exceptions to the terms "employee," "employer," "employ," or "independent contractor," and any extensions of employer status or liability, that are expressly made by a provision of this code, the Unemployment Insurance Code, or in an applicable order of the Industrial Welfare Commission, including, but not limited to, the definition of "employee" in subdivision 2(E) of Wage Order No. 2, shall remain in effect for the purposes set forth therein.
>
> (3) If a court of law rules that the three-part test in paragraph (1) cannot be applied to a particular context based on grounds other than an express exception to employment status as provided under paragraph (2), then the determination of employee or independent contractor status in that context shall instead be governed by the California Supreme Court's decision in S.G. Borello & Sons, Inc. v. Department of Industrial Relations (1989) 48 Cal.3d 341.

AB 5 also provides an extensive list of occupations that are exempt from the application of Section 2750.3(a)(1). These exemptions are subject to revision. In addition, AB 5 amends Section 3351 of the California Labor Code and Sections 606.5 and 621 of the Unemployment Insurance Code. The pertinent sections of the California Labor Code and Unemployment Insurance Code may be accessed at http://leginfo.legislature.ca.gov. You may also access the California Labor & Workforce Development Agency webpage at https://www.labor.ca.gov/employmentstatus/ for more information.

This notice does not change the policy to which it is attached.

WORKERS' COMPENSATION DISCLOSURE FORM
IMPORTANT NOTICE TO POLICYHOLDERS

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 Policyholder's Right To Appeal Classification

   Your insurers 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 worker's compensation insurance premium, you need to direct your questions to your insurer or the insurer's authorized representative within 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 or Pinnacol Assurance 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

   Because there are different types of case management services available and prescribed by insurers, it is suggested that each insurer include the type of case management services available by the individual insurer.

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

NOTICE TO POLICYHOLDERS

NOTICE: THIS WORKERS' COMPENSATION POLICY CONTAINS A DEDUCTIBLE OPTION, UNDER WHICH YOU THE EMPLOYER, ARE REQUIRED TO REIMBURSE CERTAIN LOSSES.

PLEASE READ THIS POLICY CAREFULLY AND UNDERSTAND ITS CONDITIONS PRIOR TO PURCHASING COVERAGE

Steve Blakey, President

Nehemiah E. Ginsburg, General Counsel

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

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

NOTICE TO EMPLOYERS

WORKERS COMPENSATION MANAGED CARE ELECTION

The undersigned and Starr Indemnity & Liability Co have elected to participate in a Managed Care Program. By its signature below, the policyholder agrees to use GALLAGHER BASSETT SERVICES INC as the sole provider of medical services for workers' compensation injuries. This agreement is an exercise of the policyholder's right under New Jersey Workers' Compensation Law to direct employees to medical providers of its choice. The goal of this program is to reduce workers' compensation costs for employers.

In consideration for participating in this Managed Care Program, a premium credit is afforded as indicated in the Extension of Information Page, Item 4, located in the insured's policy. This credit is contingent upon the continued utilization of this Managed Care Program during the term of the policy, and may be revoked at any time for failure to comply with these terms.

Please sign this form and return to your insurance agent.

Policyholder Signature: _____

Date: _____

Named Insured: MEDSPEED, LLC

Policy Number: 100 0004019

Effective Date: 12/31/2020

Expiration Date: 12/31/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

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

Policy Number	Policy Period From	To
100 0004019	12/31/2020	12/31/2021
	12:01 A.M. Standard Time at the mailing address of the Insured as stated herein	
Renewal Of	**Transaction**	
100 0004019	**Renewal Business**	

1. Named Insured and Mailing Address	Agent
MEDSPEED, LLC 140 INDUSTRIAL DR. ELMHURST IL 60126	CLAUDIA MANDATO 444 W 47TH ST STE 900 KANSAS CITY MO 64112

UNEMPLOYMENT ID #	CARRIER #	FEIN #	Risk ID #	Entity of Insured
	11193	364279497	911666006	LIMITED LIABILITY CO

Other Workplaces Not Shown Above: See attached Location Schedule

2. The Policy Period is from 12/31/2020 to 12/31/2021 12:01 a.m. Standard Time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: IL, AL, AZ, CA, CO, CT, DC, FL, GA, ID, IN, MD, MI, MN, MO, NJ, NM, NY, NC, PA, SD, TN, TX, VA, WI

B. Employers Liability Insurance: Part TWO of the policy applies to work in each state listed in Item 3A. The limits of our liability under Part TWO are:

Bodily Injury by Accident	$	1,000,000	each accident
Bodily Injury by Disease	$	1,000,000	policy limit
Bodily Injury by Disease	$	1,000,000	each employee

C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here: All states except North Dakota, Ohio, Washington, Wyoming, Puerto Rico and states designated in item 3. A. above. .
AR DE HI IA KS KY LA ME MA MS MT NE NH NV OK OR RI SC UT VT WV

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

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

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

Total Estimated Annual Premium	$	2,545,002
Expense Constant	$	280
Premium Discount	$ -	319,490
Deposit Premium	$	2,545,002

Minimum Premium $ 1,500

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

Countersigned this Day of ,

Issued Date: 12/31/2020

Issuing Office

Steve Blakey

AUTHORIZED REPRESENTATIVE

Workers Compensation and Employers Liability Insurance Policy

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

INFORMATION PAGE

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

Policy Number	
100 0004019	12/31/2020 12/31/2021 12:01 A.M. Standard Time at the mailing address of the Insured as stated herein
Renewal Of	
100 0004019	**Renewal Business**

Item 1. Named Insured and Mailing Address	**Producer and Mailing Address (This section is not a part of Item 1.)**
MEDSPEED, LLC 140 INDUSTRIAL DR. ELMHURST IL 60126	CLAUDIA MANDATO 444 W 47TH ST STE 900 KANSAS CITY MO 64112

NCCI Carrier Code No.	FEIN #	Entity of Insured
11193	364279497	LIMITED LIABILITY CO

Other Workplaces Not Shown Above: See attached Location Schedule.

Item 2. The Policy Period is from 12/31/2020 to 12/31/2021 12:01 a.m. Standard Time at the Insured's mailing address.

Item 3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: IL, AL, AZ, CA, CO, CT, DC, FL, GA, ID, IN, MD, MI, MN, MO, NJ, NM, NY, NC, PA, SD, TN, TX, VA, WI

B. Employers Liability Insurance: Part TWO of the policy applies to work in each state listed in Item 3A. The limits of our liability under Part TWO are:

Bodily Injury by Accident	$	1,000,000	each accident
Bodily Injury by Disease	$	1,000,000	policy limit
Bodily Injury by Disease	$	1,000,000	each employee

C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here:
AR DE HI IA KS KY LA ME MA MS MT NE NH NV OK OR RI SC UT VT WV

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

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

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium	$	2,545,002
Expense Constant	$	280
Florida Workers' Compensation Insurance Guaranty Association Surcharge	$	1,265
Total Cost	$	2,545,002

Minimum Premium $ 1,500

Premium Adjustment Period: ☒ Annual; ☐ Semiannual; ☐ Quarterly; ☐ Monthly

Countersigned this Day of ,

Issued Date: 12/31/2020

Issuing Office

Steve Blakey

AUTHORIZED REPRESENTATIVE

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

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

Workers Compensation and Employers Liability Insurance Policy

Policy Number	Policy Period From	To
100 0004019	12/31/2020	12/31/2021
	12:01 A.M. Standard Time at the mailing address of the Insured as stated herein	
Renewal Of	**Transaction**	
100 0004019	**Renewal Business**	

1. Named Insured and Mailing Address	**Agent**
MEDSPEED, LLC 140 INDUSTRIAL DR. ELMHURST IL 60126	CLAUDIA MANDATO 444 W 47TH ST STE 900 KANSAS CITY MO 64112

NJ TIN#	NCCI#	FEIN #	Risk ID #	Entity of Insured
364279497000	11193	364279497	911666006	LIMITED LIABILITY CO

Other Workplaces Not Shown Above: See attached Location Schedule

2. The Policy Period is from 12/31/2020 to 12/31/2021 12:01 a.m. Standard Time at the mailing address of the Ins

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: IL, AL, AZ, CA, CO, CT, DC, FL, GA, ID, IN, MD, MI, MN, MO, NJ, NM, NY, NC, PA, SD, TN, TX, VA, WI

B. Employers Liability Insurance: Part TWO of the policy applies to work in each state listed in Item 3A. The limits of our liability under Part TWO are:

Bodily Injury by Accident	$	1,000,000	each accident
Bodily Injury by Disease	$	1,000,000	policy limit
Bodily Injury by Disease	$	1,000,000	each employee

C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here: All states except North Dakota, Ohio, Washington, Wyoming, Puerto Rico and states designated in item 3. A. above..
AR DE HI IA KS KY LA ME MA MS MT NE NH NV OK OR RI SC UT VT WV

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

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

SEE EXTENSION OF INFORMATION PAGE

Premium for increased limits Part Two, if applicable	$	3,182
Total Premium subject to the experience modification	$	230,481
Premium modified to reflect experience modification of 0.860000	$	198,214
Other premium charges	$	-99,107
Total Estimated Standard Premium	$	99,107
Premium Discount, If applicable, 8.2 %	$ -	319,490
Expense Constant Charge	$	280
Total Estimated Premium	$	2,545,002
Second Injury Fund Surcharge	$	10,585
Uninsured Employers Fund Surcharge	$	
Total Estimated Cost	$	2,545,002

Minimum Premium: $1,500 **Deposit Premium** $2,545,002

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

Countersigned this Day of ,
Issued Date: 12/31/2020

Steve Blakey
AUTHORIZED REPRESENTATIVE

Issuing Office

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
ALABAMA					
UNIT: 00002 ADDRESS: 2415 SECOND AVE SOUTH PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	144,075	8.230000	$	11,857.00
	MANUAL PREMIUM			**$**	**11,857.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	11,857	0.014000	$	166.00
0930	WAIVER OF SUBROGATION	11,857	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	12,273	0.800000	$	-2,455.00
9887	SCHEDULED CREDIT	9,818	0.250000	$	-2,455.00
0063	PREMIUM DISCOUNT	7,363	0.115000	$	-847.00
9740	TERRORISM	144,075	0.008000	$	12.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	144,075	0.016000	$	23.00
	STATE TOTAL			**$**	**6,551.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
ARIZONA					
UNIT: 00003 ADDRESS: 4022 E BROADWAY STE 114 PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	282,335	6.170000	$	17,420.00
8810	CLERICAL OFFICE EMPLOYEES NOC	98,233	0.120000	$	118.00
	MANUAL PREMIUM			**$**	**17,538.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	17,538	0.011000	$	193.00
0930	WAIVER OF SUBROGATION	17,538	1.020000	$	351.00
9898	EXPERIENCE MODIFICATION	18,082	0.800000	$	-3,616.00
9887	SCHEDULED CREDIT	14,466	0.250000	$	-3,617.00
0063	PREMIUM DISCOUNT	10,849	0.115000	$	-1,248.00
9740	TERRORISM	380,568	0.010000	$	38.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	380,568	0.010000	$	38.00
	STATE TOTAL			**$**	**9,677.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
CALIFORNIA					
UNIT: 00004 ADDRESS: 172 COMMERCIAL STREET PERIOD: 12/31/2020 TO 12/31/2021					
7198	PARCEL DELIVERY AND MESSENGER SERVICE COMPANIES - INCLUDING TERMINAL EMPLOYEES AND MECHANICS - NO HANDLING OF BULK MERCHANDISE OR FREIGHT	1,600,030	14.130000	$	226,084.00
8742	SALESPERSONS - OUTSIDE	200,000	0.680000	$	1,360.00
8810	CLERICAL OFFICE EMPLOYEES	191,865	0.470000	$	902.00
	MANUAL PREMIUM			**$**	**228,346.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	228,346	0.028000	$	6,394.00
0930	WAIVER OF SUBROGATION	228,346	1.020000	$	4,567.00
9898	EXPERIENCE MODIFICATION	239,307	0.650000	$	-83,757.00
9887	SCHEDULED CREDIT	155,550	0.420000	$	-65,331.00
0063	PREMIUM DISCOUNT	90,219	0.115000	$	-10,375.00
CI GAS	CALIFORNIA INSURANCE GUARANTEE ASSOCIATION SURCHARGE	81,079	1.000000	$	0.00
CA AST	CALIFORNIA WORKERS COMPENSATION FRAUD ASSESSMENT FACTOR	81,079	1.003349	$	272.00
CA LEC	CA LABOR ENFORCEMENT & COMPLIANCE FUND	81,079	1.003813	$	309.00
CA OSH	CA OCCUPATIONAL SAFETY & HEALTH FUND	81,079	1.003918	$	318.00
CA SIB	CALIFORNIA SUBSEQUENT INJURIES BENEFIT TRUST FUND ASSESSMENT	81,079	1.004829	$	392.00
CA SRG	CALIFORNIA USER FUNDING SURCHARGE	81,079	1.017040	$	1,382.00
CA UEB	CALIFORNIA UNINSURED EMPLOYERS BENEFIT TRUST FUND ASSESSMENT	81,079	1.001274	$	103.00
9740	TERRORISM	1,991,895	0.041000	$	817.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	1,991,895	0.021000	$	418.00
	STATE TOTAL			**$**	**83,855.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
COLORADO					
UNIT: 00005 ADDRESS: 5800 FRANKLIN ST PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	56,583	7.640000	$	4,323.00
	MANUAL PREMIUM			**$**	**4,323.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	4,323	0.011000	$	48.00
9898	EXPERIENCE MODIFICATION	4,371	0.800000	$	-874.00
9887	SCHEDULED CREDIT	3,497	0.250000	$	-874.00
0063	PREMIUM DISCOUNT	2,623	0.115000	$	-302.00
9740	TERRORISM	56,583	0.007000	$	4.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	56,583	0.015000	$	8.00
	STATE TOTAL			**$**	**2,333.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
CONNECTICUT					
UNIT: 00006 ADDRESS: NO FIXED ADDRES PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	78,936	15.400000	$	12,156.00
	MANUAL PREMIUM			**$**	**12,156.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	12,156	0.011000	$	134.00
0930	WAIVER OF SUBROGATION	12,156	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	12,540	0.800000	$	-2,508.00
9887	SCHEDULED CREDIT	10,032	0.250000	$	-2,508.00
0063	PREMIUM DISCOUNT	7,524	0.115000	$	-865.00
CM ASM	CT W/C FUND ASSESSMENT	7,524	1.023000	$	173.00
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	6,699	1.022500	$	151.00
9740	TERRORISM	78,936	0.040000	$	32.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	78,936	0.010000	$	8.00
	STATE TOTAL			**$**	**7,023.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
DISTRICT OF COLUMBIA					
UNIT: 00007 ADDRESS: 1150 VARNUM SE NE PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	42,909	7.560000	$	3,244.00
	MANUAL PREMIUM			**$**	**3,244.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	3,244	0.011000	$	36.00
0930	WAIVER OF SUBROGATION	3,244	1.020000	$	250.00
9898	EXPERIENCE MODIFICATION	3,530	0.800000	$	-706.00
0063	PREMIUM DISCOUNT	2,824	0.115000	$	-325.00
DC SRG	WORKERS COMPENSATION POLICY HOLDER SURCHARGE	2,556	1.000000	$	0.00
9740	TERRORISM	42,909	0.116000	$	50.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	42,909	0.017000	$	7.00
	STATE TOTAL			**$**	**2,556.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
FLORIDA					
UNIT: 00008 ADDRESS: NO FIXED ADDRESS PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	2,311,559	7.410000	$	171,287.00
8742	SALESPERSONS OR COLLECTORS-OUTSIDE	* IF ANY *	0.350000	$	0.00
8810	CLERICAL OFFICE EMPLOYEES NOC	679,231	0.170000	$	1,155.00
	MANUAL PREMIUM			**$**	**172,442.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	172,442	0.014000	$	2,414.00
0930	WAIVER OF SUBROGATION	172,442	1.020000	$	3,449.00
9898	EXPERIENCE MODIFICATION	178,305	0.800000	$	-35,661.00
0063	PREMIUM DISCOUNT	142,644	0.115000	$	-16,404.00
FL GAS	FL WC GUARANTY ASSOC SURCHARGE	126,539	1.010000	$	1,265.00
9740	TERRORISM	2,990,790	0.010000	$	299.00
	STATE TOTAL			**$**	**127,804.00**

Issued Date: 01/22/2021

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
GEORGIA					
UNIT: 00009 ADDRESS: NO FIXED ADDRESS PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	864,252	14.330000	$	123,847.00
8810	CLERICAL OFFICE EMPLOYEES NOC	265,683	0.170000	$	452.00
	MANUAL PREMIUM			**$**	**124,299.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	124,299	0.011000	$	1,367.00
0930	WAIVER OF SUBROGATION	124,299	1.020000	$	2,486.00
9898	EXPERIENCE MODIFICATION	128,152	0.800000	$	-25,630.00
9846	DRUG FREE WORKPLACE CREDIT	61,513	0.075000	$	-4,613.00
9887	SCHEDULED CREDIT	102,522	0.400000	$	-41,009.00
0063	PREMIUM DISCOUNT	56,900	0.115000	$	-6,544.00
GA IIP	GA INSURERS INSOLVENCY POOL	50,673	1.000000	$	0.00
9740	TERRORISM	1,129,935	0.009000	$	102.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	1,129,935	0.019000	$	215.00
	STATE TOTAL			**$**	**50,673.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
IDAHO					
UNIT: 00010 ADDRESS: 2230 S. COLE RD PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	617,471	6.970000	$	43,038.00
8810	CLERICAL OFFICE EMPLOYEES NOC	144,269	0.220000	$	317.00
	MANUAL PREMIUM			**$**	**43,355.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	43,355	0.011000	$	477.00
0930	WAIVER OF SUBROGATION	43,355	1.020000	$	867.00
9898	EXPERIENCE MODIFICATION	44,699	0.800000	$	-8,940.00
9887	SCHEDULED CREDIT	35,759	0.250000	$	-8,940.00
0063	PREMIUM DISCOUNT	26,819	0.115000	$	-3,084.00
9740	TERRORISM	761,740	0.010000	$	76.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	761,740	0.010000	$	76.00
	STATE TOTAL			**$**	**23,887.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
ILLINOIS					
UNIT: 00001 ADDRESS: 140 INDUSTRIAL DR. PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	9,525,842	11.700000	$	1,114,524.00
8810	CLERICAL OFFICE EMPLOYEES NOC	12,783,361	0.120000	$	15,340.00
	MANUAL PREMIUM			**$**	**1,129,864.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	1,129,864	0.014000	$	15,818.00
0930	WAIVER OF SUBROGATION	1,129,864	1.020000	$	22,597.00
9898	EXPERIENCE MODIFICATION	1,168,279	0.800000	$	-233,656.00
9887	SCHEDULED CREDIT	934,623	0.400000	$	-373,849.00
0063	PREMIUM DISCOUNT	560,774	0.115000	$	-64,489.00
0900	EXPENSE CONSTANT			$	280.00
IICS	ILLINOIS INDUSTRIAL COMMISSION SURCHARGE	508,166	1.010100	$	5,132.00
9740	TERRORISM	22,309,203	0.035000	$	7,808.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	22,309,203	0.017000	$	3,793.00
	STATE TOTAL			**$**	**513,298.00**

Issued Date: 01/22/2021

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
INDIANA					
UNIT: 00011 ADDRESS: 100 FARABEE DRIVE SOUTH PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	3,955,898	5.190000	$	205,311.00
8810	CLERICAL OFFICE EMPLOYEES NOC	797,606	0.140000	$	1,117.00
	MANUAL PREMIUM			**$**	**206,428.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	206,428	0.011000	$	2,271.00
0930	WAIVER OF SUBROGATION	206,428	1.020000	$	4,129.00
9898	EXPERIENCE MODIFICATION	212,828	0.800000	$	-42,566.00
9887	SCHEDULED CREDIT	170,262	0.420000	$	-71,510.00
0063	PREMIUM DISCOUNT	98,752	0.115000	$	-11,356.00
0935	SECOND INJURY FUND ASSESSMENT	88,489	1.008300	$	734.00
9740	TERRORISM	4,753,504	0.008000	$	380.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	4,753,504	0.015000	$	713.00
	STATE TOTAL			**$**	**89,223.00**

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MARYLAND					
UNIT: 00012 ADDRESS: 654 FREDERICK STREET PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	1,537,486	13.580000	$	208,791.00
8810	CLERICAL OFFICE EMPLOYEES NOC	290,768	0.120000	$	349.00
	MANUAL PREMIUM			**$**	**209,140.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	209,140	0.011000	$	2,301.00
0930	WAIVER OF SUBROGATION	209,140	1.020000	$	4,183.00
9898	EXPERIENCE MODIFICATION	215,624	0.800000	$	-43,125.00
9887	SCHEDULED CREDIT	172,499	0.250000	$	-43,125.00
0063	PREMIUM DISCOUNT	129,374	0.115000	$	-14,878.00
9740	TERRORISM	1,828,254	0.077000	$	1,408.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	1,828,254	0.019000	$	347.00
	STATE TOTAL			**$**	**116,251.00**

STARR INDEMNITY
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MICHIGAN					
UNIT: 00013 ADDRESS: 24834 FORTERRA DR PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY	2,693,884	5.930000	$	159,747.00
8810	CLERICAL OFFICE EMPLOYEES NOC	584,218	0.100000	$	584.00
	MANUAL PREMIUM			**$**	**160,331.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	160,331	0.011000	$	1,764.00
0930	WAIVER OF SUBROGATION	162,095	1.020000	$	3,242.00
9898	EXPERIENCE MODIFICATION	165,337	0.740000	$	-42,988.00
9887	SCHEDULED CREDIT	122,349	0.250000	$	-30,587.00
0063	PREMIUM DISCOUNT	91,762	0.115000	$	-10,553.00
9740	TERRORISM	3,278,102	0.015000	$	492.00
	STATE TOTAL			**$**	**81,701.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MINNESOTA					
UNIT: 00014 ADDRESS: 110 GARFIELD AVE PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY-ALL EMPLOYEES & DRIVERS	3,370,778	9.590000	$	323,258.00
8810	CLERICAL OFFICE EMPLOYEES NOC	613,637	0.130000	$	798.00
	MANUAL PREMIUM			**$**	**324,056.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	324,056	0.011000	$	3,565.00
0174	MINNESOTA SPECIAL COMPENSATION FUND ASSESSMENT	267,282	1.034000	$	9,088.00
0988	REINSURANCE ASSOCIATION DEFICIENCY ASSESSMENT	267,282	1.000000	$	0.00
0930	WAIVER OF SUBROGATION	324,056	1.020000	$	6,481.00
9898	EXPERIENCE MODIFICATION	334,102	0.800000	$	-66,820.00
0063	PREMIUM DISCOUNT	267,282	0.115000	$	-30,737.00
9740	TERRORISM	3,984,415	0.020000	$	797.00
	STATE TOTAL			**$**	**246,430.00**

STARR INDEMNITY
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Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
MISSOURI					
UNIT: 00015 ADDRESS: 1600 SWIFT PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	122,263	10.390000	$	12,703.00
	MANUAL PREMIUM			**$**	**12,703.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	12,703	0.011000	$	140.00
0930	WAIVER OF SUBROGATION	12,703	1.020000	$	254.00
9898	EXPERIENCE MODIFICATION	13,097	0.800000	$	-2,619.00
9887	SCHEDULED CREDIT	10,478	0.250000	$	-2,620.00
0063	PREMIUM DISCOUNT	7,858	0.115000	$	-904.00
MO SRG	MISSOURI WORKERS COMPENSATION PREMIUM SURCHARGE	6,964	1.030000	$	209.00
MO SSS	MO SIF SUPPLEMENTAL SCHG	6,964	1.020000	$	139.00
9740	TERRORISM	122,263	0.008000	$	10.00
	STATE TOTAL			**$**	**7,312.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

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Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NEW JERSEY					
UNIT: 00018 ADDRESS: NO FIXED ADDRESS PERIOD: 12/31/2020 TO 12/31/2021					
7231	MESSENGER OR COURIER SERVICE - & DRIVERS	1,687,258	13.440000	$	226,767.00
8810	CLERICAL OFFICE EMPLOYEES NOC	295,322	0.180000	$	532.00
	MANUAL PREMIUM			**$**	**227,299.00**
6199	INCREASED LIMITS OF EMPLOYERS LIABILITY	227,299	0.014000	$	3,182.00
0935	NJ SECOND INJURY FUND SURCHARGE	198,214	1.053400	$	10,585.00
0936	NEW JERSEY UNINSURED FUND	198,214	1.000000	$	0.00
9898	EXPERIENCE MODIFICATION	230,481	0.860000	$	-32,267.00
9874	NJ MANAGED CARE CREDIT 15%	198,214	0.150000	$	-29,732.00
9887	SCHEDULED CREDIT	198,214	0.350000	$	-69,375.00
0063	PREMIUM DISCOUNT	99,107	0.082000	$	-8,127.00
9740	TERRORISM	1,982,580	0.030000	$	595.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	1,982,580	0.010000	$	198.00
	STATE TOTAL			**$**	**102,358.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

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Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NEW MEXICO					
UNIT: 00019 ADDRESS: 2725 BROADBENT PKWY NE PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	1,385,908	7.580000	$	105,052.00
8810	CLERICAL OFFICE EMPLOYEES NOC	186,561	0.240000	$	448.00
	MANUAL PREMIUM			**$**	**105,500.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	105,500	0.011000	$	1,161.00
0930	WAIVER OF SUBROGATION	105,500	1.020000	$	2,110.00
9898	EXPERIENCE MODIFICATION	108,771	0.800000	$	-21,754.00
9887	SCHEDULED CREDIT	87,017	0.150000	$	-13,053.00
0063	PREMIUM DISCOUNT	73,964	0.115000	$	-8,506.00
9740	TERRORISM	1,572,469	0.008000	$	126.00
	STATE TOTAL			**$**	**65,584.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

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Agent:	CLAUDIA MANDATO 0502726

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NEW YORK					
UNIT: 00020 ADDRESS: 4988 STATE HIGHWAY 30 PERIOD: 12/31/2020 TO 12/31/2021					
7231	MESSENGER SERVICE COMPANIES-DELIVERING MAIL, PARCELS OR	173,629	14.120000	$	24,516.00
8810	CLERICAL OFFICE EMPLOYEES NOC	27,966	0.180000	$	50.00
	MANUAL PREMIUM			**$**	**24,566.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	24,566	0.000000	$	0.00
0930	WAIVER OF SUBROGATION	24,566	1.020000	$	491.00
9898	EXPERIENCE MODIFICATION	25,057	0.800000	$	-5,011.00
9887	SCHEDULED CREDIT	20,046	0.050000	$	-1,002.00
0063	PREMIUM DISCOUNT	19,044	0.115000	$	-2,190.00
9749	WC SECURITY FUND ASSESSMENT	18,013	1.000000	$	0.00
NY IDE	NY INSURANCE DEPARTMENT EXPENSE	20,203	1.000000	$	0.00
0932	NEW YORK STATE ASSESSMENT - ALL OTHER CLASSES	20,203	1.122000	$	2,465.00
9740	TERRORISM	201,595	0.066000	$	133.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	201,595	0.012000	$	24.00
	STATE TOTAL			**$**	**19,476.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE
CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NORTH CAROLINA					
UNIT: 00016 ADDRESS: 3400 S VARDELL LANE PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	5,015,124	7.810000	$	391,681.00
8810	CLERICAL OFFICE EMPLOYEES NOC	1,057,321	0.110000	$	1,163.00
	MANUAL PREMIUM			**$**	**392,844.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	392,844	0.011000	$	4,321.00
0930	WAIVER OF SUBROGATION	392,844	1.020000	$	7,857.00
9898	EXPERIENCE MODIFICATION	405,022	0.800000	$	-81,004.00
9887	SCHEDULED CREDIT	324,018	0.400000	$	-129,607.00
0063	PREMIUM DISCOUNT	194,411	0.115000	$	-22,357.00
9740	TERRORISM	6,072,445	0.008000	$	486.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	6,072,445	0.015000	$	911.00
	STATE TOTAL			**$**	**173,451.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019

Named Insured: MEDSPEED, LLC

Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
NORTH DAKOTA					
UNIT: 00017 ADDRESS: 6218 53RD AVE S PERIOD: 12/31/2020 TO 12/31/2021					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	399.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	399	0.028000	$	11.00
	STATE TOTAL			**$**	**410.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019

Named Insured: MEDSPEED, LLC

Agent: CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
OHIO					
UNIT: 00049 ADDRESS: 334-360 GEST STREET PERIOD: 12/31/2020 TO 12/31/2021					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	62.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	62	0.028000	$	2.00
	STATE TOTAL			**$**	**64.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
PENNSYLVANIA					
UNIT: 00022 ADDRESS: 1707 PENNSYLVANIA AVE PERIOD: 12/31/2020 TO 12/31/2021					
808	PARCEL DELIVERY COMPANY	2,235,698	4.500000	$	100,606.00
953	OFFICE	716,340	0.120000	$	860.00
	MANUAL PREMIUM			**$**	**101,466.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	101,466	0.014000	$	1,421.00
0930	WAIVER OF SUBROGATION	101,466	1.020000	$	2,029.00
9898	EXPERIENCE MODIFICATION	104,916	1.140000	$	14,688.00
9887	SCHEDULED CREDIT	119,604	0.250000	$	-29,901.00
0063	PREMIUM DISCOUNT	89,703	0.115000	$	-10,316.00
0938	PENNSYLVANIA EMPLOYER ASSESSMENT	80,893	1.020200	$	1,634.00
9740	TERRORISM	2,952,038	0.034000	$	1,004.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	2,952,038	0.017000	$	502.00
	STATE TOTAL			**$**	**82,527.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
SOUTH DAKOTA					
UNIT: 00023 ADDRESS: 800 E 50TH STREET NORTH PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	1,381,406	8.600000	$	118,801.00
8810	CLERICAL OFFICE EMPLOYEES NOC	202,480	0.170000	$	344.00
	MANUAL PREMIUM			**$**	**119,145.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	119,145	0.011000	$	1,311.00
0930	WAIVER OF SUBROGATION	119,145	1.020000	$	2,383.00
9898	EXPERIENCE MODIFICATION	122,839	0.800000	$	-24,568.00
9887	SCHEDULED CREDIT	98,271	0.250000	$	-24,568.00
0063	PREMIUM DISCOUNT	73,703	0.115000	$	-8,476.00
SDWCPF	SD WC INSURANCE POLICY FEE	0	1.000000	$	14.00
9740	TERRORISM	1,583,886	0.009000	$	143.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	1,583,886	0.017000	$	269.00
	STATE TOTAL			**$**	**65,653.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
TENNESSEE					
UNIT: 00024 ADDRESS: 220 GREAT CIRCLE RD PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	592,918	5.160000	$	30,595.00
8810	CLERICAL OFFICE EMPLOYEES NOC	296,829	0.110000	$	327.00
	MANUAL PREMIUM			**$**	**30,922.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	30,922	0.014000	$	433.00
0930	WAIVER OF SUBROGATION	30,922	1.020000	$	618.00
9841	DRUG-FREE WORKPLACE CREDIT	31,973	0.050000	$	-1,599.00
9898	EXPERIENCE MODIFICATION	30,374	0.800000	$	-6,075.00
9887	SCHEDULED CREDIT	24,299	0.250000	$	-6,075.00
0063	PREMIUM DISCOUNT	18,224	0.115000	$	-2,096.00
9740	TERRORISM	889,747	0.008000	$	71.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	889,747	0.016000	$	142.00
	STATE TOTAL			**$**	**16,341.00**

Issued Date: 01/22/2021

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
TEXAS					
UNIT: 00025 ADDRESS: 2201 DENTON DR PERIOD: 12/31/2020 TO 12/31/2021					
7380	CHAUFFEURS, DRIVERS & THEIR HELPERS NOC - COMMERCIAL	4,457,833	3.080000	$	137,301.00
8810	CLERICAL OFFICE EMPLOYEES NOC	1,199,359	0.100000	$	1,199.00
	MANUAL PREMIUM			**$**	**138,500.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	138,500	0.014000	$	1,939.00
0930	WAIVER OF SUBROGATION	138,500	1.020000	$	2,770.00
9898	EXPERIENCE MODIFICATION	143,209	0.800000	$	-28,642.00
9887	SCHEDULED CREDIT	114,567	0.400000	$	-45,827.00
0063	PREMIUM DISCOUNT	68,740	0.122000	$	-8,386.00
9740	TERRORISM	5,657,192	0.024000	$	1,358.00
	STATE TOTAL			**$**	**61,712.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
VIRGINIA					
UNIT: 00026 ADDRESS: 2720 PROSPERITY AVE PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES -- ALL EMPLOYEES & DRIVERS	1,581,746	10.300000	$	162,920.00
8810	CLERICAL OFFICE EMPLOYEES NOC	205,161	0.110000	$	226.00
	MANUAL PREMIUM			**$**	**163,146.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	163,146	0.011000	$	1,795.00
0930	WAIVER OF SUBROGATION	163,146	1.020000	$	3,263.00
9898	EXPERIENCE MODIFICATION	168,204	0.800000	$	-33,641.00
9887	SCHEDULED CREDIT	134,563	0.150000	$	-20,184.00
0063	PREMIUM DISCOUNT	114,379	0.115000	$	-13,154.00
9740	TERRORISM	1,786,907	0.045000	$	804.00
	STATE TOTAL			**$**	**102,029.00**

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
WASHINGTON					
UNIT: 00027 ADDRESS: 5009 PACIFIC HWY# 13 PERIOD: 12/31/2020 TO 12/31/2021					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	63.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	63	0.028000	$	2.00
	STATE TOTAL			**$**	**65.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
WISCONSIN					
UNIT: 00028 ADDRESS: 3165 YEAGER DR PERIOD: 12/31/2020 TO 12/31/2021					
7231	MAIL, PARCEL, OR PACKAGE DELIVERY AND COURIER OR MESSENGER SERVICE COMPANIES--ALL EMPLOYEES AND DRIVERS	5,904,203	11.210000	$	661,861.00
8810	CLERICAL OFFICE EMPLOYEES NOC	1,065,313	0.190000	$	2,024.00
	MANUAL PREMIUM			**$**	**663,885.00**
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	663,885	0.011000	$	7,303.00
0930	WAIVER OF SUBROGATION	663,885	1.020000	$	13,278.00
9898	EXPERIENCE MODIFICATION	684,466	0.800000	$	-136,893.00
0063	PREMIUM DISCOUNT	547,573	0.115000	$	-62,971.00
9740	TERRORISM	6,969,516	0.020000	$	1,394.00
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	6,969,516	0.010000	$	697.00
	STATE TOTAL			**$**	**486,693.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

EXTENSION OF INFORMATION PAGE

CLASSIFICATION OF OPERATIONS

Code No.	Classification Description	Premium Basis Total Est. Annual Remuneration	Rate Per 100 of Remuneration		Estimated Annual Premium
WYOMING					
UNIT: 00029 ADDRESS: NO FIXED ADDRESS PERIOD: 12/31/2020 TO 12/31/2021					
9139	STOP GAP EMPLOYERS LIABILITY	0	FLAT	$	63.00
9812	INCREASED LIMITS OF EMPLOYERS LIABILITY	63	0.028000	$	2.00
	STATE TOTAL			**$**	**65.00**
	POLICY TOTAL			**$**	**2,545,002.00**

Issued Date: 01/22/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

NAMED INSURED SCHEDULE

Loc Nbr 00001
NAMED INSURED
MEDSPEED, LLC
140 INDUSTRIAL DR.
ELMHURST IL 60126
FEIN: 365279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

Loc Nbr 00002
NAMED INSURED
MEDSPEED, LLC
2415 SECOND AVE SOUTH
BIRMINGHAM AL 35223
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00003
NAMED INSURED
MEDSPEED, LLC
4022 E BROADWAY STE 114
PHOENIX AZ 85040
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00004
NAMED INSURED
MEDSPEED, LLC
172 COMMERCIAL STREET
SUNNYVALE CA 94086
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00005
NAMED INSURED
MEDSPEED, LLC
5800 FRANKLIN ST
DENVER CO 80216
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00006
NAMED INSURED
MEDSPEED, LLC
NO FIXED ADDRES
NO FIXED CITY CT 06606
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00007
NAMED INSURED
MEDSPEED, LLC
1150 VARNUM SE NE
WASHINGTON DC 20017
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00008
NAMED INSURED
MEDSPEED, LLC
NO FIXED ADDRESS
NO FIXED CITY FL 99999
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00009
NAMED INSURED
MEDSPEED, LLC
NO FIXED ADDRESS
NO FIXED CITY GA 30339
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00010
NAMED INSURED
MEDSPEED, LLC
2230 S. COLE RD
BOISE ID 83709
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 100 0004019
Named Insured: MEDSPEED, LLC
Agent: CLAUDIA MANDATO 0502726

NAMED INSURED SCHEDULE

Loc Nbr 00011
NAMED INSURED
MEDSPEED, LLC
100 FARABEE DRIVE SOUTH
LAFAYETTE IN 47905
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

Loc Nbr 00012
NAMED INSURED
MEDSPEED, LLC
654 FREDERICK STREET
HAGERSTOWN MD 21740
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00013
NAMED INSURED
MEDSPEED, LLC
24834 FORTERRA DR
DETROIT MI 48089
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00014
NAMED INSURED
MEDSPEED, LLC
110 GARFIELD AVE
DULUTH MN 55816
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00015
NAMED INSURED
MEDSPEED, LLC
1600 SWIFT
NORTH KANSAS CITY MO 64116
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00016
NAMED INSURED
MEDSPEED, LLC
3400 S VARDELL LANE
CHARLOTTE NC 28202
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00017
NAMED INSURED
MEDSPEED, LLC
6218 53RD AVE S
FARGO ND 58104
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00018
NAMED INSURED
MEDSPEED, LLC
NO FIXED ADDRESS
NO FIXED CITY NJ 99999
FEIN: 364279497
NJTIN 364279497000
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00019
NAMED INSURED
MEDSPEED, LLC
2725 BROADBENT PKWY NE
ALBUQUERQUE NM 87110
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00020
NAMED INSURED
MEDSPEED, LLC
4988 STATE HIGHWAY 30
AMSTERDAM NY 12010
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

NAMED INSURED SCHEDULE

Loc Nbr 00021
NAMED INSURED
MEDSPEED, LLC
145 REASER CT
ELYRIA OH 44035
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

Loc Nbr 00022
NAMED INSURED
MEDSPEED, LLC
1707 PENNSYLVANIA AVE
PITTSBURGH PA 15233
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00023
NAMED INSURED
MEDSPEED, LLC
800 E 50TH STREET NORTH
SIOUX FALLS SD 57104
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00024
NAMED INSURED
MEDSPEED, LLC
220 GREAT CIRCLE RD
NASHVILLE TN 37228
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00025
NAMED INSURED
MEDSPEED, LLC
2201 DENTON DR
AUSTIN TX 78758
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00027
NAMED INSURED
MEDSPEED, LLC
5009 PACIFIC HWY# 13
FIFE WA 98424
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00028
NAMED INSURED
MEDSPEED, LLC
3165 YEAGER DR
GREEN BAY WI 54311
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

00029
NAMED INSURED
MEDSPEED, LLC
NO FIXED ADDRESS
NO FIXED CITY WY 99999
FEIN: 364279497
UNEMPLOYMENT ID#
EFFECTIVE: 12/31/2020
EXPIRATION: 12/31/2021

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00001	MEDSPEED, LLC 140 INDUSTRIAL DR. ELMHURST IL 60126
00030	MEDSPEED, LLC 414 N OAKLEY CHICAGO IL 60612
00031	MEDSPEED, LLC 614 N 6TH ST SPRINGFIELD IL 62702
00002	MEDSPEED, LLC 2415 SECOND AVE SOUTH BIRMINGHAM AL 35223
00003	MEDSPEED, LLC 4022 E BROADWAY STE 114 PHOENIX AZ 85040
00032	MEDSPEED, LLC 2301 N FORBES TUCSON AZ 85745
00004	MEDSPEED, LLC 172 COMMERCIAL STREET SUNNYVALE CA 94086
00005	MEDSPEED, LLC 5800 FRANKLIN ST DENVER CO 80216
00006	MEDSPEED, LLC NO FIXED ADDRES NO FIXED CITY CT 06606
00007	MEDSPEED, LLC 1150 VARNUM SE NE WASHINGTON DC 20017
00008	MEDSPEED, LLC NO FIXED ADDRESS NO FIXED CITY FL 99999
00033	MEDSPEED, LLC 826 CREIGHTON PENSACOLA FL 32504-7097
00034	MEDSPEED, LLC 4270 L. B. MCLEOD RD ORLANDO FL 32811-5680
00035	MEDSPEED, LLC 2009 MICCOUSKEE RD TALLAHASSEE FL 32308-5359

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00009	MEDSPEED, LLC NO FIXED ADDRESS NO FIXED CITY GA 30339
00036	MEDSPEED, LLC 2270 NORTHWEST PKWY SE MARIETTA GA 30067
00037	MEDSPEED, LLC 2334 DEFOOR HILLS RD NW ATLANTA GA 30318
00010	MEDSPEED, LLC 2230 S. COLE RD BOISE ID 83709
00011	MEDSPEED, LLC 100 FARABEE DRIVE SOUTH LAFAYETTE IN 47905
00038	MEDSPEED, LLC 8435 GEORGETOWN RD INDIANAPOLIS IN 46268
00039	MEDSPEED, LLC 3500 179TH STREET HAMMOND IN 46320
00012	MEDSPEED, LLC 654 FREDERICK STREET HAGERSTOWN MD 21740
00040	MEDSPEED, LLC 3730 COMMERCE DRIVE STE 1206 BALTIMORE MD 21227
00041	MEDSPEED, LLC 505 E CHURCH ST FREDERICK MD 21701
00013	MEDSPEED, LLC 24834 FORTERRA DR DETROIT MI 48089
00042	MEDSPEED, LLC 21555 MELROSE AVE SOUTHFIELD MI 48075
00043	MEDSPEED, LLC 1717 SHAFFER ST KALAMAZOO MI 49048
00044	MEDSPEED, LLC 800 S WASHINGTON ST SAGINAW MI 48601-2551

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00045	MEDSPEED, LLC 200 HEMLOCK RD TAWAS CITY MI 48763-9237
00046	MEDSPEED, LLC 109 2ND AVE NE BRAINERD MN 56401
00015	MEDSPEED, LLC 1600 SWIFT NORTH KANSAS CITY MO 64116
00018	MEDSPEED, LLC NO FIXED ADDRESS NO FIXED CITY NJ 99999
00020	MEDSPEED, LLC 4988 STATE HIGHWAY 30 AMSTERDAM NY 12010
00017	MEDSPEED, LLC 6218 53RD AVE S FARGO ND 58104
00049	MEDSPEED, LLC 334-360 GEST STREET CINCINNATI OH 45203
00014	MEDSPEED, LLC 110 GARFIELD AVE DULUTH MN 55816
00047	MEDSPEED, LLC 5121 WINNETKA NEW HOPE MN 55428
00048	MEDSPEED, LLC 777 S. NEW BALLAS ROAD, SUITE ST. LOUIS MO 63141
00019	MEDSPEED, LLC 2725 BROADBENT PKWY NE ALBUQUERQUE NM 87110
00016	MEDSPEED, LLC 3400 S VARDELL LANE CHARLOTTE NC 28202
00021	MEDSPEED, LLC 145 REASER CT ELYRIA OH 44035
00022	MEDSPEED, LLC 1707 PENNSYLVANIA AVE PITTSBURGH PA 15233

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00023	MEDSPEED, LLC 800 E 50TH STREET NORTH SIOUX FALLS SD 57104
00024	MEDSPEED, LLC 220 GREAT CIRCLE RD NASHVILLE TN 37228
00050	MEDSPEED, LLC 1700 MEDICAL CENTER PKWY MURFREESBORO TN 37129-2245
00025	MEDSPEED, LLC 2201 DENTON DR AUSTIN TX 78758
00051	MEDSPEED, LLC 2500 TANGLEWILDE HOUSTON TX 77063
00052	MEDSPEED, LLC 2110 RESEARCH ROW DALLAS TX 75235
00053	MEDSPEED, LLC 6501 BOEING DR. STE J-5 EL PASO TX 79925
00056	MEDSPEED, LLC 4700 ELMO ROAD, STE. 116 COLLEGE STATION TX 77645
00026	MEDSPEED, LLC 2720 PROSPERITY AVE FAIRFAX VA 22031
00027	MEDSPEED, LLC 5009 PACIFIC HWY# 13 FIFE WA 98424
00028	MEDSPEED, LLC 3165 YEAGER DR GREEN BAY WI 54311
00054	MEDSPEED, LLC 3317 BEHRENS PARKWAY SHEBOYGAN WI 53081
00055	MEDSPEED, LLC 2001 E GLENDALE AVE APPLETON WI 54911
00057	MEDSPEED, LLC 1745 S. 38TH STREET MILWAUKEE WI 53215

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ADDITIONAL LOCATION SCHEDULE

Loc Nbr	Name & Address
00058	MEDSPEED, LLC 2236 HEIMSTEAD ROAD EAU CLAIRE WI 54703
00059	MEDSPEED, LLC 1804 STATE ROAD LACROSSE WI 54601
00060	MEDSPEED, LLC 1410 GREEN WAY CROSS STREET MADISON WI 53713
00029	MEDSPEED, LLC NO FIXED ADDRESS NO FIXED CITY WY 99999

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	WC000000C	1/15	WC & EL POLICY
AL	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
AL	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
AL	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
AL	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
AL	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
AL	WC000404	4/84	PENDING RATE CHANGE ENDT
AL	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
AL	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
AL	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
AL	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
AL	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
AL	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
AL	WC000425	5/17	EXPER RATING MOD FACTOR REV
AL	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
AL	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
AZ	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
AZ	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
AZ	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
AZ	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
AZ	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
AZ	WC000404	4/84	PENDING RATE CHANGE ENDT
AZ	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
AZ	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
AZ	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
AZ	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
AZ	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
AZ	WC000425	5/17	EXPER RATING MOD FACTOR REV
AZ	WC020601B	8/20	AZ CANC & NONRENEWAL ENDT
AZ	WC990606AZ	5/12	AZ KNOWLEDGE OF OCCURRENCE EN

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
CA	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
CA	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
CA	WC000404	4/84	PENDING RATE CHANGE ENDT
CA	WC000406A	7/95	PREMIUM DISCOUNT ENDT
CA	WC000419	1/01	PREMIUM DUE DATE ENDT
CA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CA	WC040301D	2/18	POLICY AMENDATORY ENDORSEMENT
CA	WC040305	1/85	CA VOLUNTARY COMPENSATION
CA	WC040306	4/84	CA WAIVER OF OUR RIGHT TO REC
CA	WC040310	1/95	CA DUTY TO DEFEND
CA	WC040421	1/08	CA OPTIONAL PREMIUM INCREASE
CA	WC040422	1/12	CA SHORT-RATE CANCELATION ENDT
CA	WC040601A	12/93	CA CANCELLATION ENDT
CA	WC040604	9/20	COVID-19 REPORTING REQ EN - CA
CA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
CA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
CO	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
CO	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
CO	WC000310	4/84	SOLE PROPRIETORS PARTNERS
CO	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
CO	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
CO	WC000404	4/84	PENDING RATE CHANGE ENDT
CO	WC000406	8/84	PREMIUM DISCOUNT ENDT
CO	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
CO	WC000419	1/01	PREMIUM DUE DATE ENDT
CO	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CO	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CO	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
CO	WC000425	5/17	EXPER RATING MOD FACTOR REV

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
CO	WC050402	11/90	CLASSIFICATION ENDT
CO	WC050403	3/93	PREM CREDIT FOR CERTIFIED RISK
CO	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
CO	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
CT	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
CT	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
CT	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
CT	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
CT	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
CT	WC000404	4/84	PENDING RATE CHANGE ENDT
CT	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
CT	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
CT	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
CT	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
CT	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
CT	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
CT	WC000425	5/17	EXPER RATING MOD FACTOR REV
CT	WC060301	4/84	CT APP OF WC INSURANCE ENDT
CT	WC060303C	7/11	CT WC FUNDS COVERAGE ENDT
CT	WC060601A	10/17	CT NONRENEWAL & RENEWAL ENDT
DC	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
DC	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
DC	WC000310	4/84	SOLE PROPRIETORS PARTNERS
DC	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
DC	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
DC	WC000404	4/84	PENDING RATE CHANGE ENDT
DC	WC000406	8/84	PREMIUM DISCOUNT ENDT
DC	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
DC	WC000419	1/01	PREMIUM DUE DATE ENDT
DC	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
DC	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
DC	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
DC	WC000425	5/17	EXPER RATING MOD FACTOR REV
DC	WC080601	4/84	DC CANCELLATION ENDT
DC	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
DC	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
FL	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
FL	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
FL	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
FL	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
FL	WC000404	4/84	PENDING RATE CHANGE ENDT
FL	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
FL	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
FL	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
FL	WC090303	8/05	FL EMPLOYERS LIAB COV ENDT
FL	WC090403B	1/15	FL TER RISK INS REAUTHZ DSC EN
FL	WC090407	7/13	FL NON-COOP WITH PREM AUDIT EN
FL	WC090606	10/98	FL EMPL & WAGE INFO RELEASE
FL	WC090607A	7/19	FL WC GUARANTY ASSOC SURCHARGE
FL	WC990605FL	4/13	FL ADVANCE NOTICE OF CANCELLAT
FL	WC990606FL	4/13	KNOWLEDGE OF OCCURRENCE ENDT
GA	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
GA	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
GA	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
GA	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
GA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
GA	WC000404	4/84	PENDING RATE CHANGE ENDT
GA	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
GA	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
GA	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
GA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
GA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
GA	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
GA	WC000425	5/17	EXPER RATING MOD FACTOR REV
GA	WC100402	1/13	GEORGIA NON-COOPERATION WITH P
GA	WC100601C	7/18	GA CANC NRN CHANGE ENDT
GA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
GA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
ID	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
ID	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
ID	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
ID	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
ID	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
ID	WC000404	4/84	PENDING RATE CHANGE ENDT
ID	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
ID	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
ID	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
ID	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
ID	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
ID	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
ID	WC000425	5/17	EXPER RATING MOD FACTOR REV
ID	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
ID	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
IL	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
IL	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
IL	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
IL	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
IL	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
IL	WC000404	4/84	PENDING RATE CHANGE ENDT
IL	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
IL	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
IL	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
IL	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
IL	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
IL	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
IL	WC000425	5/17	EXPER RATING MOD FACTOR REV
IL	WC120601F	1/19	IL AMENDATORY ENDT
IL	WC120603	1/19	IL RENEWAL ENDORSEMENT
IL	WC990605IL	5/12	IL ADVANCED NOTICE OF CANCELLA
IL	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
IN	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
IN	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
IN	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
IN	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
IN	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
IN	WC000404	4/84	PENDING RATE CHANGE ENDT
IN	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
IN	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
IN	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
IN	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
IN	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
IN	WC000425	5/17	EXPER RATING MOD FACTOR REV
IN	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
IN	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
MD	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
MD	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
MD	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
MD	WC000311A	8/91	VOLUNTARY COMP ENDT
MD	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
MD	WC000404	4/84	PENDING RATE CHANGE ENDT

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MD	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
MD	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
MD	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
MD	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
MD	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
MD	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
MD	WC000425	5/17	EXPER RATING MOD FACTOR REV
MD	WC190401	7/93	MD CONST CLASS PREM ADJ ENDT
MD	WC190601G	10/17	MD CANCELLATION AND N/R ENDT
MD	WC190602	1/14	MD NOTIF OF 45 DAY U/W PRD END
MD	WC990605MD	5/12	MD ADVANCED NOTICE OF CANCELLA
MI	WC000301	4/84	ALTERNATE EMPLOYER ENDT
MI	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
MI	WC000404	4/84	PENDING RATE CHANGE ENDT
MI	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
MI	WC210303A	6/97	MI NOTICE TO POLICYHOLDER ENDT
MI	WC210304	4/84	MI LAW ENDORSEMENT
MI	WC210402B	1/15	TERRORISM RISK INS ACT ENDT
MI	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
MI	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
MN	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
MN	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
MN	WC000310	4/84	SOLE PROPRIETORS PARTNERS
MN	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
MN	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
MN	WC000406A	7/95	PREMIUM DISCOUNT ENDT
MN	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
MN	WC000419	1/01	PREMIUM DUE DATE ENDT
MN	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
MN	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END

STARR INDEMNITY
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Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MN	WC000425	5/17	EXPER RATING MOD FACTOR REV
MN	WC220000A	11/03	AMENDATORY ENDT
MN	WC220601D	8/06	MN CANCELLATION & NONRENEWL EN
MN	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
MN	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
MO	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
MO	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
MO	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
MO	WC000311A	8/91	VOLUNTARY COMP ENDT
MO	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
MO	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
MO	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
MO	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
MO	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
MO	WC000425	5/17	EXPER RATING MOD FACTOR REV
MO	WC240302	1/14	MO NOTIF OF ADDNL M B ENDT.
MO	WC240401	1/90	MO CONTR PREM ADJ ENDT
MO	WC240601B	1/96	MO CANC/NRN ENDT
MO	WC240602B	7/06	MO PROP & CAS GUARANTY ASSOC
MO	WC240604C	9/19	MO AMENDATORY ENDORSEMENT
MO	WC990605MO	7/12	MO ADVANCED NOTICE OF CANCELLA
MO	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
NJ	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
NJ	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
NJ	WC000404	4/84	PENDING RATE CHANGE ENDT
NJ	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
NJ	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
NJ	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NJ	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NJ	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NJ	WC000425	5/17	EXPER RATING MOD FACTOR REV
NJ	WC290306B	7/07	NJ PART TWO EMPLOYERS LIAB END
NJ	WC290307	4/00	NJ SOLE PROPRIETORS & PARTNERS
NJ	WC290409A	1/96	NJ APPROVED MANAGED CARE
NM	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
NM	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
NM	WC000310	4/84	SOLE PROPRIETORS PARTNERS
NM	WC000311A	8/91	VOLUNTARY COMP ENDT
NM	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
NM	WC000404	4/84	PENDING RATE CHANGE ENDT
NM	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
NM	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
NM	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
NM	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NM	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
NM	WC000425	5/17	EXPER RATING MOD FACTOR REV
NM	WC300601A	3/15	NM CANC AND NRN ENDT
NM	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
NM	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
NY	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
NY	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
NY	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
NY	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
NY	WC000404	4/84	PENDING RATE CHANGE ENDT
NY	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
NY	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
NY	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
NY	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NY	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NY	WC000425	5/17	EXPER RATING MOD FACTOR REV

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NY	WC310308	1/00	NY LIMIT OF LIABILITY ENDT
NY	WC310319J	5/20	NY CONSTR CLASS PREM ADJ PROG
NY	WC310618A	5/20	NY NOTICE OF RIGHT TO APPEAL
NC	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
NC	WC000310	4/84	SOLE PROPRIETORS PARTNERS
NC	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
NC	WC000313	4/84	WAIVER OF OUR RIGHT TO RECOVER
NC	WC000404	4/84	PENDING RATE CHANGE ENDT
NC	WC000406A	7/95	PREMIUM DISCOUNT ENDT
NC	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
NC	WC000419	1/01	PREMIUM DUE DATE ENDT
NC	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
NC	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
NC	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
NC	WC000425	5/17	EXPER RATING MOD FACTOR REV
NC	WC320301D	7/18	AMENDED COV ENDT
NC	WC320304	1/09	ALTERNATE EMPLOYER ENDT
ND	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
ND	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
ND	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
ND	WC990636	2/18	ND AMEND END EMP LIABILITY COV
OH	WC340301C	3/10	STOP GAP EMPLOYER'S LIABILITY
OH	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
OH	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
PA	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
PA	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
PA	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
PA	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
PA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
PA	WC000404	4/84	PENDING RATE CHANGE ENDT

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
PA	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
PA	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
PA	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
PA	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
PA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
PA	WC000425	5/17	EXPER RATING MOD FACTOR REV
PA	WC370401	1/17	PA AUDIT NONCOMPLIANCE CHARGE
PA	WC370601	4/84	PA SPECIAL ENDT INSP MANUAL
PA	WC370602	4/84	PA NOTICE
PA	WC370603A	8/95	PA ACT 86-1986 ENDT
PA	WC370604	10/99	PA EMPLOYER ASSESSMENT ENDT
PA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
PA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
SD	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
SD	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
SD	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
SD	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
SD	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
SD	WC000404	4/84	PENDING RATE CHANGE ENDT
SD	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
SD	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
SD	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
SD	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
SD	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
SD	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
SD	WC000425	5/17	EXPER RATING MOD FACTOR REV
SD	WC400601A	7/11	SD DIRECT ACTION STATUTE
SD	WC400603	1/94	SD MANAGED CARE ENDMNT
SD	WC400605B	4/06	SD CANCELLATION AND NONRENEW
SD	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
SD	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
TN	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
TN	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
TN	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
TN	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
TN	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
TN	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
TN	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
TN	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
TN	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
TN	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
TN	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
TN	WC000425	5/17	EXPER RATING MOD FACTOR REV
TN	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
TX	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
TX	WC000301	4/84	ALTERNATE EMPLOYER ENDT
TX	WC000311A	8/91	VOL COMP & EL COV END
TX	WC000406	8/84	PREMIUM DISCOUNT ENDORSEMENT
TX	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
TX	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
TX	WC000425	5/17	EXPER RATING MOD FACTOR REV
TX	WC420301J	6/20	TX AMENDATORY ENDORSEMENT
TX	WC420304B	6/14	TX WAIVER OF RIGHT TO RECOVER
TX	WC420310	1/97	TX SOLE PROP PARTNERS ENDT
TX	WC420408A	6/14	TX HEALTH CARE NETWORK ENDT
TX	WC990626	9/17	ADVANCED NOTICE OF CANCELLATIO
VA	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
VA	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
VA	WC000310	4/84	SOLE PROPRIETORS PARTNERS
VA	WC000311A	8/91	VOLUNTARY COMP & EL ENDT

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
VA	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
VA	WC000404	4/84	PENDING RATE CHANGE ENDT
VA	WC000406	8/84	PREMIUM DISCOUNT ENDT
VA	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
VA	WC000419	1/01	PREMIUM DUE DATE ENDT
VA	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
VA	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
VA	WC000425	5/17	EXPER RATING MOD FACTOR REV
VA	WC450602	7/93	AMENDATORY ENDT
VA	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO
VA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
WA	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
WA	WC990605WA	5/12	WA ADVANCED NOTICE OF CANCELLA
WA	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT
WI	WC000115	1/20	NT EN PNDG LAW CHG TRIPRA 2015
WI	WC000301A	2/89	ALTERNATE EMPLOYER ENDT
WI	WC000310	4/84	SOLE PROPRIETORS, PARTNERS
WI	WC000311A	8/91	VOLUNTARY COMP & EL ENDT
WI	WC000313	4/84	WAIVER OF RIGHTS TO RECOVER
WI	WC000406A	7/95	PREMIUM DISCOUNT ENDORSEMENT
WI	WC000414A	1/19	NOTIFICATION OF CHG IN OWNER
WI	WC000419	1/01	PREMIUM DUE DATE ENDORSEMENT
WI	WC000421D	1/15	CATASTROPHE (O/T C.A.T.)PRM EN
WI	WC000422B	1/15	TERR RISK INS REAUTHZ DISC END
WI	WC000424	1/17	AUDIT NONCOMPLIANCE CHARGE END
WI	WC000425	5/17	EXPER RATING MOD FACTOR REV
WI	WC480601C	4/01	WI LAW ENDT
WI	WC480606B	1/02	WI CANC/NRN ENDT
WY	WC000303C	10/04	STOP GAP EMPLOYER'S LIABILITY
WY	WC990605	5/12	ADVANCED NOTICE OF CANCELLATIO

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	100 0004019
Named Insured:	MEDSPEED, LLC
Agent:	CLAUDIA MANDATO 0502726

ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
WY	WC990606	5/12	KNOWLEDGE OF OCCURRENCE ENDT

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. **The Policy**

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

B. **Who is Insured**

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

C. **Workers Compensation Law**

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

D. **State**

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

E. **Locations**

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

PART ONE
WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

C. **We Will Defend**

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

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

D. **We Will Also Pay**

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

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

E. **Other Insurance**

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

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

F. **Payments You Must Make**

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

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

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

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

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

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

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

C. **Exclusions**

This insurance does not cover:

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

D. **We Will Defend**

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

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

E. **We Will Also Pay**

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

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

F. **Other Insurance**

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

G. **Limits of Liability**

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

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

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

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

H. **Recovery From Others**

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

I. **Actions Against Us**

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

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

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

PART THREE
OTHER STATES INSURANCE

A. **How This Insurance Applies**

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

B. **Notice**

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

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

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

proceeding or suit.

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

PART FIVE - PREMIUM

A. **Our Manuals**

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

B. **Classifications**

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

C. **Remuneration**

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

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

D. **Premium Payments**

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

E. **Final Premium**

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

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

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

F. **Records**

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

G. **Audit**

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

PART SIX - CONDITIONS

A. **Inspection**

We have the right, but are not obliged to inspect

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

B. **Long Term Policy**

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

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

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

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

D. **Cancelation**

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

E. **Sole Representative**

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

NOTIFICATION ENDORSEMENT OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015

This endorsement is being attached 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 B) 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 2015 (TRIPRA 2015), 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 2015, in whole or in part, TRIPRA 2015 is scheduled to expire on December 31, 2020.

Since the timetable for any further Congressional action regarding TRIPRA 2015 is presently unknown, and exposure to acts of terrorism remains, we are providing policyholders with relevant information concerning their workers compensation policies in the event of the TRIPRA 2015's expiration.

Your policy provides coverage for workers compensation losses caused by acts of terrorism, 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 that your policy provides for terrorism losses is shown in Item 4 of the policy Information Page or the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B) Schedule that is attached to your policy. This amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2020, in the event of TRIPRA 2015'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: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

Alternate Employer	Address	State of Special or Temporary Employment
Any alternate employer of your employees	ANY ADDRESS MICHIGAN	MICHIGAN

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

Alternate Employer	**Address**	**State of Special or Temporary Employment**
Any alternate employer of your employees	ANY ADDRESS TEXAS	TEXAS

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS ALABAMA

2. State of Special or Temporary Employment

   ALABAMA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS ARIZONA

2. State of Special or Temporary Employment

   ARIZONA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

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The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS CALIFORNIA

2. State of Special or Temporary Employment

   CALIFORNIA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS COLORADO

2. State of Special or Temporary Employment

   COLORADO

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

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The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS CONNETICUT

2. State of Special or Temporary Employment

   CONNETICUT

3. Contract or Project

   ANY CONTRACT

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(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: _____

ALTERNATE EMPLOYER ENDORSEMENT

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

1. Alternate Employer — Address

   Any alternate employer of your employees — DISTRICT OF COLUMBIA

2. State of Special or Temporary Employment

   DISTRICT OF COLUMBIA

3. Contract or Project

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

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The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

1. Alternate Employer

   Any alternate employer of your employees

   Address

   FLORIDA

2. State of Special or Temporary Employment

   FLORIDA

3. Contract or Project

   ANY CONTRACT

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Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS GEORGIA

2. State of Special or Temporary Employment

   GEORGIA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS IDAHO

2. State of Special or Temporary Employment

IDAHO

3. Contract or Project

ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS ILLINOIS

2. State of Special or Temporary Employment

   ILLINOIS

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS INDIANA

2. State of Special or Temporary Employment

   INDIANA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS MARYLAND

2. State of Special or Temporary Employment

MARYLAND

3. Contract or Project

ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

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Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

1. Alternate Employer

   Any alternate employer of your employees

   Address

   ANY ADDRESS
   MINNESOTA

2. State of Special or Temporary Employment

   MINNESOTA

3. Contract or Project

   ANY CONTRACT

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

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Endorsement Effective: Policy No.: Endorsement No.:

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Insurance Company: Countersigned by: _____

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Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS MISSOURI

2. State of Special or Temporary Employment

   MISSOURI

3. Contract or Project

   ANY CONTRACT

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

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Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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Schedule

1. Alternate Employer

   Any alternate employer of your employees

   Address
   ANY ADDRESS
   NEW JERSEY

2. State of Special or Temporary Employment

   NEW JERSEY

3. Contract or Project

   ANY CONTRACT

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Insurance Company: Countersigned by: _____

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Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS NEW MEXICO

2. State of Special or Temporary Employment

NEW MEXICO

3. Contract or Project

ANY CONTRACT

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Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS PENNSYLVANIA

2. State of Special or Temporary Employment

PENNSYLVANIA

3. Contract or Project

ANY CONTRACT

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Insurance Company: Countersigned by: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS SOUTH DAKOTA

2. State of Special or Temporary Employment

   SOUTH DAKOTA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS TENNESSEE

2. State of Special or Temporary Employment

   TENNESSEE

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS VIRGINIA

2. State of Special or Temporary Employment

   VIRGINIA

3. Contract or Project

   ANY CONTRACT

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: _____

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

	Alternate Employer	Address
1.	Any alternate employer of your employees	ANY ADDRESS WISCONSIN

2. State of Special or Temporary Employment

   WISCONSIN

3. Contract or Project

   ANY CONTRACT

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: _____

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

NORTH DAKOTA
WASHINGTON
WYOMING

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: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
ALL PARTNERS	ILLINOIS
ALL PARTNERS	ALABAMA
ALL PARTNERS	ARIZONA
ALL PARTNERS	COLORADO
ALL PARTNERS	CONNECTICUT
Officers:	
ALL OFFICERS	ILLINOIS
ALL OFFICERS	ALABAMA
ALL OFFICERS	ARIZONA
ALL OFFICERS	COLORADO
ALL OFFICERS	CONNECTICUT
Others:	

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: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
ALL PARTNERS	DISTRICT OF COLUMBIA
ALL PARTNERS	FLORIDA
ALL PARTNERS	GEORGIA
ALL PARTNERS	IDAHO
ALL PARTNERS	INDIANA
Officers:	
ALL OFFICERS	DISTRICT OF COLUMBIA
ALL PARTNERS	FLORIDA
ALL OFFICERS	GEORGIA
ALL OFFICERS	IDAHO
ALL OFFICERS	INDIANA
Others:	

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: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
ALL PARTNERS	MARYLAND
ALL PARTNERS	MINNESOTA
ALL PARTNERS	MISSOURI
ALL PARTNERS	NORTH CAROLINA
ALL PARTNERS	NEW MEXICO
Officers:	
ALL OFFICERS	MARYLAND
ALL OFFICERS	MINNESOTA
ALL OFFICERS	MISSOURI
ALL OFFICERS	NORTH CAROLINA
ALL OFFICERS	NEW MEXICO
Others:	

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: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons	State
Sole Proprietor:	
Partners:	
ALL PARTNERS	PENNSYLVANIA
ALL PARTNERS	SOUTH DAKOTA
ALL PARTNERS	TENNESSEE
ALL PARTNERS	VIRGINIA
ALL PARTNERS	WISCONSIN
Officers:	
ALL OFFICERS	PENNSYLVANIA
ALL OFFICERS	SOUTH DAKOTA
ALL OFFICERS	TENNESSEE
ALL OFFICERS	VIRGINIA
ALL OFFICERS	WISCONSIN
Others:	

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: _____

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement adds Voluntary Compensation Insurance to the policy.

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

C. **Exclusions**

This insurance does not cover:

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

D. **Before We Pay**

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

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

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

E. **Recovery From Others**

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

F. **Employers Liability Insurance**

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

Schedule

Employees	State of Employment	Designated Workers Compensation Law
All officers and employees not subject to the workers compensation law except masters and members of the crew of any vessel.	Any state designated in item 3A of the information page of this policy.	State of hire

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: _____

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

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

Schedule

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PENDING RATE CHANGE ENDORSEMENT

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

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

Schedule

State

ALABAMA
ARIZONA
CALIFORNIA
COLORADO
CONNECTICUT
DISTRICT OF COLUMBIA
FLORIDA
GEORGIA
IDAHO
ILLINOIS
INDIANA
MARYLAND
MICHIGAN
NEW JERSEY
NEW YORK
NEW MEXICO
NORTH CAROLINA
PENNSYLVANIA
SOUTH DAKOTA
VIRGINIA

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

State	Estimated Eligible Premium First	Next	Next	Balance
ALABAMA	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
COLORADO	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
CONNECTICUT	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
DISTRICT OF COLUMBIA	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____%

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

State	Estimated Eligible Premium			
	First	Next	Next	Balance
GEORGIA	$10,000	$190,000	$1,555,000	Over $1,755,000
	0.0%	9.1%	11.3%	12.3%
MARYLAND	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
MISSOURI	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%
NEW MEXICO	$10,000	$190,000	$1,555,000	$1,755,000
	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: _____%

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

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

2. Average percentage discount: _____%

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1.

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

2. Average percentage discount: _____%

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1. State

Estimated Eligible Premium

	First $10,000	Next $190,000	Next $1,550,000	Balance
ARIZONA	0.0%	9.1%	11.3%	12.3%
CALIFORNIA	0.0%	9.1%	11.3%	12.3%
FLORIDA	0.0%	9.1%	11.3%	12.3%
IDAHO	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1. State

Estimated Eligible Premium

	First $10,000	Next $190,000	Next $1,550,000	Balance
ILLINOIS	0.0%	9.1%	11.3%	12.3%
INDIANA	0.0%	9.1%	11.3%	12.3%
MICHIGAN	0.0%	9.1%	11.3%	12.3%
MINNESOTA	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1. State

Estimated Eligible Premium

	First $10,000	Next $190,000	Next $1,550,000	Balance
NEW JERSEY	0.0%	9.1%	11.3%	12.3%
NORTH CAROLINA	0.0%	9.1%	11.3%	12.3%
WISCONSIN	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

3. Other policies:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

90-DAY REPORTING REQUIREMENT—NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

You must report any change in ownership to us in writing within 90 days of the date of the change. 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. 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.

Failure to report any change in ownership, regardless of whether the change is reported within 90 days of such change, may result in revision of the experience rating modification factor used to determine your premium.

This reporting requirement applies regardless of whether an experience rating modification is currently applicable to 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: _____

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
ALABAMA	0.016000	$23.00
ARIZONA	0.010000	$38.00
CALIFORNIA	0.021000	$418.00
COLORADO	0.015000	$8.00
CONNECTICUT	0.010000	$8.00
DISTRICT OF COLUMBIA	0.017000	$7.00
GEORGIA	0.019000	$215.00
IDAHO	0.010000	$76.00
ILLINOIS	0.017000	$3,793.00
INDIANA	0.015000	$713.00

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
MARYLAND	0.019000	$347.00
NEW JERSEY	0.010000	$198.00
NEW YORK	0.012000	$24.00
NORTH CAROLINA	0.015000	$911.00
PENNSYLVANIA	0.017000	$502.00
SOUTH DAKOTA	0.017000	$269.00
TENNESSEE	0.016000	$142.00
WISCONSIN	0.010000	$697.00

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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

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

Definitions

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

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

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

a. The act is an act of terrorism.

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

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

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

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

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

Limitation of Liability

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

Policyholder Disclosure Notice

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

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

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

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

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

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

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

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

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

Schedule

State	Rate	Premium
ALABAMA	0.008000	$12.00
ARIZONA	0.010000	$38.00
CALIFORNIA	0.041000	$817.00
COLORADO	0.007000	$4.00
CONNECTICUT	0.040000	$32.00
DISTRICT OF COLUMBIA	0.116000	$50.00
GEORGIA	0.009000	$102.00
IDAHO	0.010000	$76.00
ILLINOIS	0.035000	$7,808.00
INDIANA	0.008000	$380.00
MARYLAND	0.077000	$1,408.00
MINNESOTA	0.020000	$797.00
MISSOURI	0.008000	$10.00
NEW JERSEY	0.030000	$595.00
NEW MEXICO	0.008000	$126.00
NEW YORK	0.066000	$133.00
NORTH CAROLINA	0.008000	$486.00
PENNSYLVANIA	0.034000	$1,004.00
SOUTH DAKOTA	0.009000	$143.00
TENNESSEE	0.008000	$71.00
TEXAS	0.024000	$1,358.00
VIRGINIA	0.045000	$804.00
WISCONSIN	0.020000	$1,394.00

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

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

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

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

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

Note:

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

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
ALABAMA	Estimated Annual Premium	2.00
ARIZONA	Estimated Annual Premium	2.00
COLORADO	Estimated Annual Premium	2.00
CONNECTICUT	Estimated Annual Premium	2.00
DISTRICT OF COLUMBIA	Estimated Annual Premium	2.00
GEORGIA	Estimated Annual Premium	2.00
IDAHO	Estimated Annual Premium	2.00
ILLINOIS	Estimated Annual Premium	2.00
MARYLAND	Estimated Annual Premium	2.00
MINNESOTA	Estimated Annual Premium	2.00

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

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

Endorsement Effective: Policy No.: Endorsement No.

Insured: Premium:

Insurance Company: Countersigned by: _____

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

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

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

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

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

Note:

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

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
NEW JERSEY	Estimated Annual Premium	2.00
NEW MEXICO	Estimated Annual Premium	2.00
NORTH CAROLINA	Estimated Annual Premium	3.00
SOUTH DAKOTA	Estimated Annual Premium	2.00
TENNESSEE	Estimated Annual Premium	2.00
VIRGINIA	Estimated Annual Premium	2.00
WISCONSIN	Estimated Annual Premium	1.00

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

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

Endorsement Effective: Policy No.: Endorsement No.

Insured: Premium:

Insurance Company: Countersigned by: _____

EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT

This endorsement is added to Part Five—Premium of the policy.

The premium for the policy is adjusted by an experience rating modification factor. The factor shown on the Information Page may be revised and applied to the policy in accordance with our manuals and endorsements. We will issue an endorsement to show the revised factor, if different from the factor shown, when it is calculated.

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: _____

Arizona Cancellation and Nonrenewal Endorsement

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

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

D. **Cancellation and Nonrenewal**

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. If you cancel or fail to renew this policy, we must promptly notify the Industrial Commission of Arizona.
3. We may cancel this policy if you fail to pay premium when due, or when one or both of the parties to a professional employer agreement terminate the agreement.
   - If we cancel or nonrenew this policy, we must provide to you and the Industrial Commission of Arizona at least 30 days' notice of the cancellation or nonrenewal. Notice may be sent via mail or email as follows:
     - Mailing that notice to you at your last-known mailing address on file with us will be sufficient proof of notice.
     - If you consented to have the notice emailed in accordance with Arizona law, emailing that notice to you at your last-known email address as provided by you to us will be sufficient proof of notice.
       - If the email notice is: (1) rejected for delivery; (2) returned to us; or (3) we become aware that the email address provided by you is no longer valid, then we will also mail that notice to you by US Postal Service certified mail, certificate of mailing, or first-class mail using intelligent mail barcode, or another similar tracking method used or approved by the US Postal Service.
   - If we nonrenew this policy and fail to give you notice of nonrenewal, coverage will not extend beyond the policy period.
4. The policy period will end on the date and time stated in the cancellation or nonrenewal notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

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 _____

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 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: Policy No.: Endorsement No.:

Insured: Insurance Company:

Countersigned by: _____

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

It is agreed that if any such person is subject to the Voluntary Compensation & Employers Liability Coverage Endorsement, the Insurer will endorse the policy within 60 days of notification.

Note:

This endorsement may be used to afford compensation coverage pursuant to the Miscellaneous Regulations for the Recording and Reporting of Data, Part 2, Section IV.

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

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: _____

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT - CALIFORNIA

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.)

You must maintain payroll records accurately segregating the remuneration of your employees while engaged in the work described in the Schedule.

The additional premium for this endorsement shall be 2.0% of the California workers' compensation premium otherwise due on such remuneration.

Schedule

Person or Organization	Job Description
Any person or organization to whom you become obligated to waive your rights of recovery against, under any contract or agreement you enter into prior to the occurrence of loss.	Where required by contract

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: _____

DUTY TO DEFEND - CALIFORNIA

The insurance afforded by Part One, Section **C, "We Will Defend",** is hereby deleted and replaced with the following:

WE WILL DEFEND

We have the right and duty to defend at our expense any claim or proceeding against you before the California Workers' Compensation Appeals Board or its equivalent in any other state (and any appeal of a decision therefrom) for the benefits payable by this workers' compensation insurance. We have the right to investigate and settle these claims or proceedings.

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

Nothing contained in this Section shall amend, modify, restrict, or otherwise alter any obligations or conditions under Part Two - Employer's Liability Insurance of the policy.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA

You must provide us, or our authorized representative, access to records necessary to perform a payroll verification audit. If you fail to provide access within 90 days after expiration of the policy, you are liable to pay a total premium equal to 3 times our current estimate of the annual premium for your policy. In addition, if you fail to provide access after our third request within a 90 day or longer period, you are also liable for our costs in attempting to perform the audit unless you provide a compelling business reason for your failure.

We will contact you to schedule appointments during normal business hours.

We will notify you of your failure to provide access by mailing a certified, return-receipt document stating the increased premium and the total amount of our costs incurred in our attempt(s) to perform an audit. In addition to any other obligations under this contract, 30 days after you receive the notification, you will be obligated to pay the total premium and costs referenced above. If, thereafter, you provide access to your records within three years after the policy expires, or within another mutually agreed upon time, and we succeed in performing the audit to our satisfaction, we will revise your total premium and the costs due to reflect the results of the audit.

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

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: _____

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

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

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

SHORT RATE CANCELLATION TABLE

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor 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

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor 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

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor 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			

Note:

1. This endorsement is pursuant to California Insurance Code section 11760.1, effective January 1, 2008.
2. This endorsement applies only to audits conducted, or attempted, on or after January 1, 2008.

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: _____

CALIFORNIA CANCELATION 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 cancelation condition in Part Six (Conditions) of the policy is replaced by these conditions:

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 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 or 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 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. 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 cancelation 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 cancelation notice.

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: _____

COVID-19 REPORTING REQUIREMENT ENDORSEMENT – CALIFORNIA

In addition to the requirements under Part 4, "Your Duties if Injury Occurs" of your policy, if you have five or more employees and an employee that is not described in California Labor Code section 3212.87 tests positive for COVID-19, you are required to report the following information as provided below.

~~Reporting COVID-19 Positive Tests from July 6, 2020 to September 17, 2020~~

Pursuant to California Labor Code Section 3212.88(k)(2), if you are aware of an employee testing positive for COVID-19 on or after July 6, 2020 and prior to September 17, 2020, you must report to your claims administrator in writing via electronic mail or facsimile within 30 business days of September 17, 2020, all of the following:

(1) An employee has tested positive. For purposes of this reporting, do not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to California Labor Code Section 5401.

(2) The date that the employee tests positive, which is the date the specimen was collected for testing.

(3) The specific address or addresses of the employee's specific place of employment during the 14-day period preceding the date of the employee's positive test.

(4) The highest number of employees who reported to work at each of the employee's specific places of employment on any given work day between July 6, 2020 and September 17, 2020.

~~Reporting COVID-19 Positive Tests from September 17, 2020 to January 1, 2023~~

Pursuant to California Labor Code Section 3212.88(i), when you know, or reasonably should know, that an employee has tested positive for COVID-19 between September 17, 2020 and January 1, 2023, you must report to your claims administrator in writing via electronic mail or facsimile within 3 business days all of the following:

(1) An employee has tested positive. For purposes of this reporting, do not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to California Labor Code Section 5401.

(2) The date that the employee tests positive, which is the date the specimen was collected for testing.

(3) The specific address or addresses of the employee's specific place of employment during the 14-day period preceding the date of the employee's positive test.

(4) The highest number of employees who reported to work at the employee's specific place of employment in the 45-day period preceding the last day the employee worked at each specific place of employment.

Labor Code Section 3212.88(j) states that the intentional submission of false or misleading information or the failure to report the above information as required may subject you to a civil penalty in the amount of up to $10,000 to be assessed by the Labor Commissioner.

For the purposes of these reporting requirements, California Labor Code Section 3212.88(m) provides the following:

(1) "COVID-19" means the 2019 novel coronavirus disease.

(2) "Test" or "testing" means a PCR (Polymerase Chain Reaction) test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA. "Test" or "testing" does not include serologic testing, also known as antibody testing. "Test" or "testing" may include any other viral culture test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA which has the same or higher sensitivity and specificity as the PCR Test.

(3) "A specific place of employment" means the building, store, facility, or agricultural field where an employee performs work at the employer's direction. "A specific place of employment" does not include the employee's home or residence, unless the employee provides home health care services to another individual at the employee's home or residence.

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 _____

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.

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: _____

COLORADO PREMIUM CREDIT FOR CERTIFIED RISK MANAGEMENT PROGRAMS ENDORSEMENT

This endorsement applies to Part One (Workers Compensation Insurance) because Colorado is listed in Item 3.A. of the Information Page.

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.

If you qualify for experience and/or schedule rating and you have implemented a certified workers compensation risk management program or service, we must allow a 5% premium credit if your loss experience has improved since your last renewal date. The Schedule below will indicate if you qualify for this credit.

If you do not qualify for experience and/or schedule rating on your workers compensation insurance and you have implemented a certified workers compensation risk managment program or service, we must offer premium credits as follows:

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

If you have selected a designated medical provider, we must allow a credit of 2.5%. If you are eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation.

If you are not eligible for experience or schedule rating, the 2.5% credit will be applied, in addition to the premium credit applicable. The combined premium credit and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%.

Schedule

% Premium Credit	Certified Risk Management Program/Designated Medical Provider
0	N/A

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

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

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

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

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

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

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

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

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

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT

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

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

F. **Nonrenewal**

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intention not to renew. Advance notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

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

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

G. **Renewal**

We may elect to renew the policy. In accordance with Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intent to renew if, compared to this policy, the terms or conditions of the renewal policy include any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles.

This conditional renewal notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

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

This conditional renewal notice will include or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal 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: _____

DISTRICT OF COLUMBIA CANCELATION ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because District of Columbia 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 notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We will mail or deliver to you and the Mayor not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing this notice to you at your mailing address last known to us will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.

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: _____

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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 you immunity from civil liability under the workers compensation laws

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: _____

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

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, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:
   a. The act is an act of terrorism.
   b. The act is violent or dangerous to human life, property or infrastructure.
   c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
   d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
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, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
   f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United StatesGovernment would pay 80% 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

Rate per $100 of payroll

0.010000

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: _____

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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.

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: _____

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

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

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

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

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

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

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

Schedule

Surcharge rate 1.0 %

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: _____

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:	Policy No.:	Endorsement No.:
Insured:	Premium:	

Insurance Company: Countersigned by: _____

GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDORSEMENT

This endorsement applies because Georgia is shown in Item 3.A. of the policy Information Page.
Part Six—Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D**. Cancellation, Nonrenewal, and Change**

1. You may cancel this policy. You must mail or deliver advance notice to us in writing, or deliver advance notice orally or electronically, stating when the cancellation is to take effect. We may require that you provide written, electronic, or other recorded verification of the request before the cancellation takes effect. The cancellation is subject to the following:
   a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.
   b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practical after receiving your request for cancellation.

      Our notice will state the effective date of cancellation, which will be the later of the following:

      1) 10 days from the date of mailing or delivering our notice, or
      2) The effective date of cancellation stated in your notice to us.
2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium, or if we nonrenew this policy, we must send a notice of cancellation or nonrenewal by certified mail, return receipt requested, to you at your last address of record at least 75 days before the effective date of cancellation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience rating modification or resulting from an audit of auditable coverages), we must deliver a notice of our action (including dollar amount of the increase in renewal premium more than 15%) to you, by first class mail, at your last address of record at least 45 days before the expiration date of this policy.
4. If we reduce the policy coverage, we must provide you with written notice at least 45 days before the effective date of the reduction in coverage. The notice will be delivered to you in person or by first class mail to your last address of record. A reduction in coverage made by us includes elimination of coverage, a decrease in scope or less coverage, or the addition of an exclusion. Requests made by you to change, reduce, or eliminate coverage are not considered reductions in coverage.
5. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days before the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.
6. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

ILLINOIS AMENDATORY ENDORSEMENT

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

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

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

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

G. Audit

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

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

A. Inspection

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

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

D. Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail to each named insured at the last known mailing address advance written notice stating when the cancellation is to take effect. We will maintain proof of mailing of the notice of cancellation. A copy of all such notices shall be sent to the broker or agent of record, if known, at the last known mailing address. The broker or agent of record may opt to accept notification electronically.
3. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least ten days before the cancellation is to take effect. If we cancel for any other reason, we will mail the notice:
   a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;
   b. At least 60 days before the cancellation is to take effect if the policy has been in force for 61 days or more.
4. If this policy has been in effect for 60 days or more, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. The policy was issued because of a material misrepresentation;
   c. You violated any of the terms and conditions of the policy;
   d. The risk originally accepted has measurably increased;
   e. The Director has determined that we no longer have adequate reinsurance to meet our needs; or
   f. The Director has determined that continuation of coverage could place us in violation of the laws of Illinois.
5. Our notice of cancellation will state our reasons for cancelling.
6. The policy period will end on the day and hour stated in the cancellation notice.

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

E. Sole Representative

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

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

F. Nonrenewal

1. We may elect not to renew the policy. We will mail to each named insured the nonrenewal notice at the last known mailing address at least 60 days prior to the expiration of the current policy. We will maintain proof of mailing of the nonrenewal notice. An exact and unaltered copy of such notice will also be sent to the named insured's producer, if known, or the producer of record at the last known mailing address. The named insured's producer, if known, or the producer of record may opt to accept notification electronically.
2. If we fail to give at least 60 days' notice prior to the expiration date of the current policy, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this policy. Additionally, in accordance with 215 ILCS 5/462a, we may be required to provide the named insured with 30 days' written notice prior to the expiration of this policy if the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.
3. Our notice of nonrenewal will provide a specific explanation on the reasons for not renewing.
4. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. You notify us or the producer who procured this policy that you do not want the policy renewed; or
   b. You fail to pay all premiums when due; or
   c. You obtain other insurance as a replacement of the policy.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

ILLINOIS RENEWAL ENDORSEMENT

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

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

G. **Renewal**

1. We may elect to renew the policy in accordance with 215 ILCS 5/143.17a.
   a. We will provide the named insured with written notice of our intent to renew if, compared to this current policy, the:
      - Renewal policy premium increases by 30% or more, or
      - Changes in deductibles or coverage materially alter the renewal policy.
   b. We will mail or deliver the written renewal notice:
      - To the named insured at the last known mailing address
      - At least 60 days prior to the renewal or anniversary date of this current policy.
   c. If we fail to provide notice 60 days prior to the renewal or anniversary date, but we do mail or deliver the written renewal notice to the named insured not less than 31 days prior to the renewal or anniversary date of this current policy, then we may extend this policy at the current terms and conditions for the period of time needed to equal the 60 day time period required to provide notice of intention to renew.
   d. All renewal notices will also be sent to the producer, if known, or the producer of record, and to the mortgagee or lien holder listed on the policy. The producer, if known, or the producer of record and the mortgagee or lien holder may opt to accept notification electronically.
   e. If we fail to provide renewal notice as required above, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this current policy. The increase in premium is based on the known exposure as of the date of the quotation compared to the premium as of the last day of coverage for the current year's policy, annualized. The renewal premium may be subsequently amended to reflect any change in exposure or reinsurance costs not considered in the quotation.
   f. If we fail to provide the notice of renewal as required, the policy will still terminate on its expiration date if:
      (1) You notify us or the producer who procured this policy that you do not want the policy renewed; or
      (2) You fail to pay all premiums when due; or
      (3) You obtain other insurance as a replacement of the policy.
   g. Proof of mailing or proof of receipt of the notice of intent to renew to the named insured may be proven by a sworn affidavit by the company as to the usual and customary business practices of mailing notice pursuant to 215 ILCS 5/143.17a or may be proven consistent with Illinois Supreme Court Rule 236.
2. We may elect to conditionally renew the policy in accordance with 215 ILCS 5/462a.
   a. For policies issued, delivered, amended, or renewed on or after January 1, 2019 ("this policy") we will provide the employer with written notice of our intent to conditionally renew if, compared to this policy, the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.
   b. To determine whether the renewal premium is in excess of 5% above the rate recommendation, we will not consider any premium increases generated from the following items:
      - Increased loss costs
      - Increased exposure units
      - The application of an experience rating modification
      - The application of a contracting classification premium adjustment program
      - The application of a large deductible program
      - The application of a retrospective rating plan
      - An audit of auditable coverages

c. Mailing or delivering such written notice to the employer at least 30 days in advance of the expiration date of this policy, at the address shown in Item 1. of the Information Page, and to the authorized agent or broker will be deemed sufficient notice under this section.

d. This conditional renewal notice will include a statement that clearly identifies:

(1) The amount of the premium increase or, if the amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based on information available
to us at that time

(2) The reason for the increased premium in excess of the rate recommendation filed with the Illinois Department of Insurance

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: _____

MARYLAND CONSTRUCTION CLASSIFICATION PREMIUM REDUCTION PROGRAM ENDORSEMENT

This premium for the policy may be reduced by the Maryland Construction Classification Premium credit factor. The factor was not available when the policy was issued. If you qualify, or if an estimated factor has been applied, we will issue an endorsement to show the proper premium reduction factor after it is calculated.

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: _____

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

D. **Cancellation and Nonrenewal**

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel or nonrenew this policy as follows:
   a. If the policy is cancelled for nonpayment of premium, we will file with the Maryland Workers Compensation Commission's designee, and serve you by certificate of mailing, not less than 10 days' advance written notice stating when the cancellation will take effect.
   b. If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service to you, not less than 45 days' advance written notice stating when the cancellation or nonrenewal will take effect.

   Mailing this notice by certified mail to you at your mailing address last known to us creates a presumption of actual delivery of notice. You may be able to rebut this presumption by providing evidence that the notice was not delivered.
3. The effective dates of the cancellation or nonrenewal are determined as follows:
   a. Except for cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation or nonrenewal notice, or 45 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
   b. For cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation notice, or 10 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
4. The provisions in D-2 and D-3 do not apply to the cancellation of a policy or binder during the 45-day underwriting period in accordance with Section 12-106 of Maryland Code, Insurance. Refer to Section 12-106 of Maryland Code, Insurance for the cancellation provisions that apply during the 45-day underwriting period.

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: _____

MARYLAND NOTIFICATION OF 45-DAY UNDERWRITING PERIOD ENDORSEMENT

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

1. Your policy is subject to a 45-day underwriting period beginning on the effective date of coverage. In accordance with Md. Code Ann. Ins. §12-106, if we discover a material risk factor during the underwriting period, we may:
   a. Cancel this policy during the underwriting period if you do not meet our underwriting standards; or
   b. Recalculate your premium from the effective date of the policy if you meet our underwriting standards.

   A material risk factor means a risk factor that:
   - Was incorrectly recorded or not disclosed by the insured in an application for insurance;
   - Was in existence on the date of the application; and
   - Modifies estimated annual premium charged on the policy in accordance with the rates and supplementary rating information filed by the carrier

   A material risk factor does not include:
   - Information that constitutes a material misrepresentation; or
   - A change initiated by an insured, including any request by the insured that results in a change in coverage, change in deductible, or other change to a policy.
2. If we recalculate your premium because we discovered a material risk factor during the underwriting period, we will provide to you, by certificate of mailing or by delivery of electronic means in accordance with Md. Code Ann. Ins. §27-601.2, written notice of the following information by no later than the end of the underwriting period:
   a. The amount of the recalculated premium;
   b. The reason for the increase or reduction in the premium; and
   c. Your right to cancel this policy and receive a pro rata refund of any premium paid by notifying us of the cancellation.
3. If you cancel this policy following receipt of a notice of recalculated premium, you will receive a pro rata refund of any premium paid, regardless of whether your policy is a retrospectively rated policy.
4. Nothing in this endorsement prohibits us from conducting an audit in accordance with the provisions of your policy or charging and collecting the final premium based on the results of the audit.
5. This endorsement does not apply if your policy is a renewal 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: _____

MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

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

   You may obtain pertinent rating information by submitting a written request to us at our address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

   You may also submit a written request for a review of the method by which your rates and premiums were determined. If you are not satisfied with the results of the review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Payroll Audits

   You may request a payroll audit once each calendar year. Your request must be in writing, sent to our address shown in this endorsement. You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

   You may request reserve and redemption information that relates to the premium for this policy. Your request must be in writing sent to our address shown in this endorsement. We will provide you with that information within thirty (30) days of receipt of your request.

   If you believe that the policy premiums are excessive because we set unreasonable reserves or because of the unreasonable redemption of a claim, you may request a meeting with our management representative. Your request must be in writing sent to our address shown in this endorsement. If you are not satisfied with the results of the meeting, you may appeal to the Insurance Commissioner at the address shown in this endorsement.

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Company Address

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

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: _____

MICHIGAN LAW ENDORSEMENT

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

Michigan law requires that we attach this paragraph to your policy in the language specified by the statute. To help you understand the paragraph, the following definitions are added:

(1) We are "the insurer issuing this policy"

(2) You are "the insured employer"

(3) "Michigan workmen's compensation act" means the Workers' Disability Compensation Act of 1969

(4) "Workmen's compensation" means workers compensation

(5) "The bureau of workmen's compensation" means the Bureau of Workers' Disability Compensation

"Notwithstanding any language elsewhere contained in this contract or policy of insurance, the accident fund or the insurer issuing this policy hereby contracts and agrees with the insured employer:

Compensation:

(a) "That it will pay to the persons that may become entitled thereto all workmen's compensation for which the insured employer may become liable under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Medical services:

(b) "That it will furnish or cause to be furnished to all employees of the employer all reasonable medical, surgical, and hospital services and medicines when they are needed which the employer may be obligated to furnish or cause to be furnished to his employees under the provisions of the Michigan workmen's compensation act and that it will pay to the persons entitled thereto for all such services and medicines when they are needed for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Rehabilitation services:

(c) "That it will furnish or cause to be furnished such rehabilitation services for which the insured employer may become liable to furnish or cause to be furnished under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Funeral expenses:

(d) "That it will pay or cause to be paid the reasonable expense of the last sickness and burial of all employees whose deaths are caused by compensable injuries or compensable occupational diseases happening during the life of this contract or policy and arising out of and in the course of their employment with the employer, which the employer may be obligated to pay under the provisions of the Michigan workmen's compensation act;

Scope of contract:

(e) "That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations assumed:

(f) "That it hereby assumes all obligations imposed upon the employer by his acceptance of the Michigan workmen's compensation act, as far as the payment of compensation, death benefits, medical, surgical, hospital care or medicine and rehabilitation services is concerned;

Termination notice:

(g) "That it will file with the bureau of workmen's compensation at Lansing, Michigan, at least 20 days before the taking effect of any termination or cancelation of this contract or policy, a notice giving the date at which it is proposed to terminate or cancel this contract or policy; and that any termination of this policy shall not be effective as far as the employees of the insured employer are concerned until 20 days after notice of proposed termination or cancelation is received by the bureau of workmen's compensation;

Conflicting provisions:

(h) "That all the provisions of this contract, if any, which are not in harmony with this paragraph are to be construed as modified hereby, and all conditions and limitations in the policy, if any, conflicting herewith are hereby made null and void."

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

Definitions

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

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

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

a. The act is an act of terrorism.
b. The act is violent or dangerous to human life, property or infrastructure.
c. The act resulted in damage within the United States, or outside 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, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums during the immediately preceding calendar year.

Limitation of Liability

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

PolicyholderDisclosureNotice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
   f. $200,000,000,with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.

2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate per $100 of Remuneration
MICHIGAN	0.015000

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: _____

MINNESOTA AMENDATORY ENDORSEMENT

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

E. **We Will Also Pay** is amended to read:

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

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Your share of pre- or postjudgement interest assuming that the principal amount of that judgement is within the applicable policy limits under this insurance; and
5. Expenses we incur.

H. **Recovery From Others** is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

PART FIVE - PREMIUM

G. **Audit** is amended to read:

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data.

We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends, except as it pertains to Part Two—Employer's Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

DEFINITIONS

As used in this policy, "rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.

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: _____

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Cancellation of a New Policy

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of cancellation.

Cancellation of Other Policies

If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk in sured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

Notice of Cancellation

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or deli vered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.

Refunds Due You

If this policy is canceled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

1. Insured elsewhere;
2. Accepted replacement coverage; or
3. Requested or agreed not to renew this policy.

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

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: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

MISSOURI CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT ENDORSEMENT

The premium for the policy may be adjusted by a Missouri Contracting Classification Premium Adjustment factor. The factor was not available when the policy was issued. If you qualify, we will issue an endorsement to show the premium adjustment factor after it is calculated.

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: _____

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.

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: _____

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: _____

MISSOURI AMENDATORY ENDORSEMENT

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

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

G. **Audit**

You will let us examine and audit all of your records relating to this policy during regular business hours throughout and after the policy period. 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 that we have under this provision.

Audits must be completed and billed, and any premiums will be returned, within 120 days of policy expiration or cancellation unless:

1. Delay is caused by your failure to respond to reasonable audit requests, provided that the requests are timely and adequately documented; or
2. A written agreement between you and us provides a longer time frame.

If you or we have any objection to the results of any audit, you or we may send a written notice demanding a reconsideration of the audit within three years from the date of expiration or cancellation of this policy. The written notice must 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 relating to this policy, and/or do not provide audit information as timely and reasonably requested, we may apply an Audit Noncompliance Charge equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge is shown in the Schedule below.

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

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

Note:

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

SCHEDULE

Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
Estimated Annual Premium	2.00

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

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

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

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NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

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

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

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

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

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

With respect to paragraph F., the “Other Insurance” provision is replaced with the following:

F. Other Insurance

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

NEW JERSEY SOLE PROPRIETORS AND PARTNERS COVERAGE ENDORSEMENT

An election was made by the individual proprietor or all partners actively performing services for this business to be deemed to be employees for the purpose of receipt of benefits under the New Jersey Workers Compensation Law. The premium for this policy will include the remuneration of the individual proprietor, all partners in any partnership, including all partners in a limited liability partnership or all members in a limited liability company. The premium shall be determined in accordance with Part Five A - "Premium", in 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: _____

NEW JERSEY APPROVED MANAGED CARE PROGRAM ENDORSEMENT

The premium reduction percentage shown in the Schedule below is applicable to your audited modified premium because you have exercised your right under the New Jersey Workers Compensation Law and agreed to use the medical services of an approved managed care organization.

The reduction amount will be estimated at policy inception and adjusted on audit. It will be prorated if the managed care program is initiated during the term of the policy or if it is terminated before normal expiration of the policy or if there is change in distribution of employees and different approved managed care programs are applicable.

We will provide you with information concerning the use of the managed care program and your rights and obligations under the program.

The premium reduction may be revoked if you fail to abide by your obligations under our managed care contract.

Schedule

Name of Approved Managed Care Organization
COVENTRY HEALTH CARE WORKER'S COMPENSATION, INC.

Effective Date of Program 12/31/2020

Premium Reduction Percentage 15 %

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: _____

Note:

This endorsement must be attached to each policy where the insured has agreed to use the services of an approved managed care program.

NEW MEXICO CANCELLATION 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.

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

D. Cancellation

1. You may cancel this policy by giving us advance written notice stating when the cancellation is to take effect.
2. At any time during the policy period, regardless of the number of days the policy has been in effect, we may cancel this policy for nonpayment of premium when due. We must give written notice to you at least 10 days prior to the effective date of the cancellation.
3. If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel this policy without cause by giving written notice to you at least 10 days prior to the effective date of the cancellation. The cancellation effective date must fall within this period of less than 60 days.
4. Subject to Subsection 2 above, if the policy has been in effect for 60 days or more or is a renewal, we may cancel this policy 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. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   b. Willful and negligent acts or omissions by you have substantially increased the hazards insured against. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   c. You presented a claim based on fraud or material misrepresentation. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   d. There has been a substantial change in the risk assumed by us since the policy was issued. We must give written notice to you at least 30 days prior to the effective date of cancellation.
   e. Revocation or suspension of driver's license of the named insured or other operator who either resides in the same household or customarily operates the vehicle. We must give written notice to you at least 15 days prior to the effective date of cancellation.
5. We will give the required Notice of Cancellation stating the reason(s) for cancellation before the cancellation is effective. The notice will state the time that the cancellation is to take effect. The written notice of cancellation will be sent to your last address of record with us.

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

F. Nonrenewal

1. If we decide not to renew this policy, we must give you written notice of our intention at least 30 days prior to the expiration of the policy. The written notice of nonrenewal will be sent to your last address of record with us.
2. This nonrenewal section does not apply to any policy of insurance issued to an insured that has its principal place of business outside the state of New Mexico.

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

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

Endorsement Effective: Policy No.: Endorsement No.
Insured: Premium:

Insurance Company: Countersigned by: _____

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

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

Credits are earned for average wages in excess of $23.24 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

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

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

The basis for determining the credit is the limited payroll of each employee for the number of hours worked (excluding overtime premium pay) for each construction classification (other than employees engaged in the construction of one or two-family residential housing). For policies with effective dates between January 1 and March 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the second calendar year preceding the policy effective date. For policies with effective dates between April 1 and December 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the calendar year preceding the policy effective date. Total payroll (and not limited payroll) is to be reported for employees engaged in the construction of one or two-family residential housing.

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

The application for credit on a renewal policy must be received by the Rating Board three (3) months prior to the policy renewal effective date. The Rating Board will accept and process an application if it is received between the renewal policy effective and expiration date, however, it must be accompanied by a letter from the employer stating the reason for the delay.

Under no circumstances will an original application be accepted for any policy if it is received after the expiration date of the policy to which the credit would have applied, nor will a revised application be accepted if it is received later than one (1) year from the expiration date of the policy to which the credit would have applied.

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

NEW YORK WORKERS' COMPENSATION POLICYHOLDER NOTICE OF RIGHT TO APPEAL

Policyholder Disputes

Policyholders are entitled to inquire, challenge and dispute issues relating to classification, ownership, premium auditing and/or other New York Compensation Insurance Rating Board ("Rating Board") rulings or decisions pertaining to this policy. Please refer to the New York Workers' Compensation Policyholder Notice of Right to Appeal process noted below.

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

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

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

New York Workers' Compensation Policyholder Notice of Right to Appeal Process

An insured, or its representative, (hereafter referred to as "insured") may appeal the application of a rule or procedure contained in the New York Workers' Compensation & Employers' Liability Manual. Rules or procedures are defined as those determinations, either by a carrier or the Rating Board, which define the variables which make up, the policy conditions. Examples include: classification codes, ownership information, premium audits, and any other determination which may affect the policy.

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

1. The Rating Board will review the request and respond to the parties within sixty (60) days, either granting the parties or their authorized representatives their request or sustaining the Rating Board's original ruling.

2. If not satisfied with the outcome of **1.** above, the parties may then request, in writing, a conference with members of the Rating Board staff. The request must state the nature of the complaint and supply any supporting documents. The appropriate Department Vice President or his or her designated representative will preside at the conference.

3. If the dispute is not resolved by the conference, the parties may then appeal to the Underwriting Committee of the Rating Board for a hearing to consider the staff ruling. This appeal must be in writing and must specify the reasons for the appeal and the nature of the complaint.

Following the Committee's receipt of the appeal request, the parties will be notified about the time and place for the hearing. The appeal will be heard at the next Underwriting Committee meeting for which appropriate time can be devoted to the matter.

After the hearing, the parties will be advised, in writing, of the Underwriting Committee decision on the complaint.

4. If the Underwriting Committee ruling is not satisfactory to either party, then the aggrieved party may request a hearing at the New York State Department of Financial Services to consider the disputed decision.

5. The decision of the New York State Department of Financial Services may be appealed to a court of law, by the parties involved or the Rating Board.

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

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

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

D. **Cancellation and Nonrenewal**

1. You may cancel this policy.

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

2. We may cancel this policy.

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

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

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

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

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

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

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

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

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

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

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

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

   (c) If we cancel for any of the reasons listed in paragraph (b), we must provide you with at least 15 days prior written notice of cancellation stating the precise reason for cancellation. We may provide this notice by registered or certified mail, return receipt requested, to you and any other person designated in the policy to receive notice of cancellation at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Whenever notice of cancellation is given by registered or certified mail, cancellation will not be effective unless and until that method is employed and completed. Notice of intent to cancel given by registered or certified mail shall be conclusively presumed completed three days after the notice is sent if, on the same day that notice is sent by registered or certified mail, the insurer also provides notice by first-class mail and by electronic means if available as defined in G.S. 58-2-255(a) to the insured and any other person designated in the policy to receive notice. Any such supplemental notice given by electronic means shall be effective for the limited purpose of establishing this conclusive presumption. Notice of cancellation may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send notice as provided in this paragraph to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

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

3. We may refuse to renew this policy:
   (a) If this policy is for a term of one year or less, we must provide you with notice of nonrenewal at least 45 days prior to the expiration date of the policy.
   (b) If this policy is for a term of more than one year or for an indefinite term, then to nonrenew the policy at the policy anniversary date we must provide you with notice of nonrenewal at least 45 days prior to the anniversary date of the policy.
   (c) The notice of nonrenewal must state the precise reason for nonrenewal. Failure to send this notice, as provided in paragraphs 3 and 5, to any other person designated in the policy to receive this notice invalidates the nonrenewal only as to that other person's interest.
   (d) Any nonrenewal attempted or made that is not in compliance with paragraphs (a), (b) and (c) is not effective. Paragraphs (a), (b) and (c) do not apply if you have obtained insurance elsewhere, have accepted replacement coverage, or have requested or agreed to nonrenewal.
4. Whenever we lower coverage limits, raise deductibles, or raise premium rates for reasons within our exclusive control and other than at your request, we will mail you written notice of the change at least 30 days in advance of the effective date of the change. As used in this paragraph, the phrase, “reasons within our exclusive control” does not mean experience modification changes, exposure changes, or loss cost rate changes.
5. We must provide the notice required by paragraphs 3 and 4 by mail to you and any other person designated in the policy to receive this notice at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Mailing copies of the notice by regular first-class mail satisfies the notice requirements of paragraphs 3, 4 and 5.
6. We will also send copies of the notice required by this endorsement to the agent or broker of record, though failure to send copies of the notice to the agent or broker of record will not invalidate a cancellation or nonrenewal. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this paragraph. Notice of nonrenewal may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

ALTERNATE EMPLOYER ENDORSEMENT

(EXCLUDING EMPLOYERS LIABILITY COVERAGE)

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

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in Item 2 of the Schedule. Part One (Workers Compensation Insurance) will apply as though the alternate employer is insured. If an entry is shown in Item 3 of the Schedule the insurance afforded by this endorsement applies only to work you perform under the contract or at the project named in the Schedule.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

Part Two (Employers Liability Insurance) will not apply to the alternate employer and no coverage will be provided for any such liability under this endorsement.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for your employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Part One and our right to inspect under Part Six.

Schedule

1. **Alternate Employer** **Address**
2. **State of Special or Temporary Employment**
3. **Contract or Project**

Any alternate employer of your employees

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: _____

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** is changed by adding these exclusions.

C. **Exclusions**

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;

14. 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 Ohio or otherwise fail to comply with that 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: _____

PENNSYLVANIA AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

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

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge (ANC).

The charge is determined by applying the ANC Multiplier to the ANC Basis shown in the table below:

ANC Basis	ANC Multiplier
Estimated Annual Premium	Two times

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

The application of the ANC is subject to the following conditions:

a) Carriers must comply with all applicable state laws and/or regulations related to audits of workers compensation insurance policies.

b) The Audit Noncompliance Charge Endorsement is optional. When used, the Audit Noncompliance Charge Endorsement and/or applicable state-specific endorsement must be attached to the policy at inception of the policy term being audited.

c) The carrier must make two attempts to obtain the audit information and/or complete the audit. At each attempt, the carrier must notify the employer regarding the specific required records and the amount of the ANC to be applied if the employer continues to refuse to comply with the audit.

d) The carrier must adequately document the audit file regarding the above attempts to obtain the required audit information.

This ANC rule applies to mail/email, telephone, computer (remote access), and physical audits, unless otherwise provided by state law.

The scenarios listed below may occur and are treated as follows:

If an ANC is applied and the employer…	**Then the carrier…**
Pays the ANC and later allows the audit	• Performs the final audit and determines the final policy premium based on the results of the audit; and • Refunds the ANC to the employer, or applies the ANC amount to any outstanding balance on the policy Submits a unit statistical correction report to remove the ANC charge from the previously reported Unit Statistical data.
Does **not** pay the ANC but later allows the audit	Performs the final audit and determines the final policy premium based on the results of the audit
Pays the ANC but does **not** later allow the audit	Does not change the previously reported: • Unit Statistical data • Noncompliance transactions
Does not pay the ANC and does **not** later allow the 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: Premium:

Insurance Company: Countersigned by: _____

SPECIAL PENNSYLVANIA ENDORSEMENT - INSPECTION OF MANUALS

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PENNSYLVANIA NOTICE

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

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

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

The Act does not apply:

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

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

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

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

Nonrenewal

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

Notice of Increase in Premium

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

Return of Unearned Premium

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

PENNSYLVANIA EMPLOYER ASSESSMENT ENDORSEMENT

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

EMPLOYER ASSESSMENT FORMULA:

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

Act 57 of 1997 Employer Assessment Factor

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

Employer Assessment Premium Base

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

CODE 0938

EMPLOYER ASSESSMENT FACTOR	**EMPLOYER ASSESSMENT**
1.020200	$ 1,634.00

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOUTH DAKOTA DIRECT ACTION STATUTE ENDORSEMENT

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

1. Your injured employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.

2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of the employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct action statute (Section 58-20-12) of the South Dakota Workers' Compensation Law.

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: _____

SOUTH DAKOTA MANAGED CARE ENDORSEMENT

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

This endorsement provides for the payment of benefits under the workers' compensation law of South Dakota to provide medical services and health care to injured workers for compensable injuries and diseases by means of a managed care program which meets the requirements extablished by the Department of Labor.

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: _____

SOUTH DAKOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is replaced by this Condition:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy.
   a. We must file a notice of intention in the office of the State Department of Labor or other officer in charge of the administration of the workers compensation law at least 10 days prior to cancellation due to nonpayment of premiums. Any policy cancelled for reasons other than nonpayment of premium requires at least 20 days notification before the effective cancellation date. This notice of intention must state the date of cancellation.
   b. We must mail or deliver to you not less than ten days advance written notice stating when the cancella tion due to nonpayment of premiums is to take effect. Any policy cancelled for reasons other than non payment of premium requires at least 20 days written notification before the effective cancellation date.
   c. Mailing that notice to you at your last known place of residence will be sufficient to prove notice.
   d. If the employer is a partnership, the notice may be given to any one of the partners.
   e. If the employer is a corporation, the notice may be given to any agent or officer of the corporation upon whom legal process may be served.
3. After sixty days from the effective date of policy issuance, a notice of cancellation may not be issued unless it is based upon at least one of the following reasons:
   a. Nonpayment of premium
   b. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Discovery of acts or omissions on the part of the named insured that increase any hazard insured against
   d. The occurrence of a change in the risk that substantially increases any hazard insured against after insurance coverage has been issued
   e. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof that substantially increases any hazard insured against
   f. A determination by the director of the Division of Insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state
   g. Violation or breach by the insured of any policy terms or conditions
   h. Such other reasons as are approved by the director of the Division of Insurance
4. The policy period will end the day and hour stated in the cancellation notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

Nonrenewal

1. We may elect not to renew. We will mail or deliver to you and your agent not less than 60 days advance written notice stating our intention not to renew this policy. Mailing notice to you at your last known address will be sufficient to prove notice.
2. A notice of nonrenewal is not required if the policyholder is transferred to an insurer that is a member of the same insurance group as the previous insurer and notice of such transfer is given in the form adopted by rule by the Division of Insurance.
3. The policy provisions control if the policy provides for a notice of refusal to renew that exceeds 60 days.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

Texas Amendatory Endorsement

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

GENERAL SECTION

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

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

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

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

PART ONE - WORKERS COMPENSATION INSURANCE

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

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

F. **Payments You Must Make**

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

H. **Statutory Provisions**

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

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

Section 6 is amended to read:

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

D. **We Will Defend**

This Section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

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

PART FIVE - PREMIUM

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

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

C. **Remuneration**

Number 2 is amended to read:

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

E. **Final Premium**

Number 2 is amended to read:

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

PART SIX - CONDITIONS

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

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

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

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

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

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

Add the following to the policy:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. **Claims Notification**

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

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

COMPLAINT NOTICE:

DISPUTE RESOLUTION SERVICES

NCCI'S DISPUTE RESOLUTION PROCESS DOES NOT APPLY TO WORKERS COMPENSATION CLAIMS.

For workers compensation claim disputes, see "CLAIM COMPLAINT" below. For issues related to a violation of law related to your policy, see "VIOLATIONS OF LAW" below.

Important Note: The dispute resolution services provided through the Dispute Resolution Process (Process) of the National Council on Compensation Insurance (NCCI) are **voluntary.** The Process is not an administrative remedy that must be exhausted before you pursue relief in court. Using the Process does not prevent you or the carrier that issued the policy from pursuing any available legal remedies at any time.
NCCI can assist in the resolution of a dispute regarding your policy that is related to any of the following matters:

- The application or interpretation of rules contained in the various NCCI manuals (including, but not limited to, classification codes and experience rating modifications)
- Rating programs
- Endorsements
- Forms

Contact the carrier that issued the policy and attempt to resolve the dispute directly. If you and the carrier cannot agree, then contact NCCI to ask for assistance. NCCI's ***Basic Manual*** addresses dispute resolution in Appendix G. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and after you have paid any undisputed premium due to the carrier.

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

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

VIOLATIONS OF LAW:

If you believe there has been a violation of law related to your policy, file a complaint with the Texas Department of Insurance:

Phone: 1-800-252-3439 **Online:** tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov **Mail:** MC 111-1A, PO Box 149091, Austin, TX 78714

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance-Division of Workers' Compensation, Compliance and Investigations by mail to 7551 Metro Center Drive, Suite 100, MS-8, Austin, TX 78744; or by fax to 512-490-1030; or by email to DWC-ComplianceReview@tdi.texas.gov.

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

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

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

The premium for this endorsement is shown in the Schedule.

Schedule

1. ( ) Specific Waiver
   Name of person or organization

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

2. Operations: All Texas Operations

3. Premium

   The premium charge for this endorsement shall be 2.0% of the premium developed on payroll in connection with work performed for the above person(s) or organization(s) arising out of the operations described.

4. Advance Premium: See Extension Page

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

Pursuant to Section 406.097, Labor Code, sole proprietors, partner(s) or corporate executive officer(s) of the named insured are covered under this workers' compensation policy, unless specifically excluded from coverage through an endorsement to the policy. Such persons may be named in the Schedule below and the premium basis for the policy shall include their remuneration.

For employees excluded from workers' compensation coverage by law, an election has been made by or on behalf of each person described in "Others" in the Schedule to be subject to the workers' compensation law of the state named in the Schedule. Such persons shall be named in the Schedule below and the premium basis for the policy shall include their remuneration.

Schedule

Persons	State
Sole Proprietor:	Texas
Partners: ALL PARTNERS	Texas
Officers: ALL OFFICERS	Texas
Others: ALL PARTNERS	Texas

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

TEXAS HEALTH CARE NETWORK ENDORSEMENT

This endorsement indicates that you have elected under this policy to provide workers compensation health care services to your injured employees through a certified workers compensation health care network that we have either established or contracted with, as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

We will provide you with information concerning the use of our certified workers compensation health care network(s) in our service area(s) and your rights and responsibilities as a participant in our network program. This includes information describing the service area(s) applicable to you and your injured employees as required in NCCI's ***Basic Manual for Workers Compensation and Employers Liability Insurance.*** In accordance with Chapter 1305 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code, we will also provide you with information that is required to be given to your employees, including an employee's notice of network requirements and an employee acknowledgement form.

Your premium may have been reduced because you have agreed to participate in our certified workers compensation health care network. The amount of the premium reduction is shown on the Information Page of this policy. The reduction is estimated at the policy inception and adjusted at final audit of the policy. The reduction may be pro-rated if you elect to participate in a certified workers compensation health care network during the policy year or if you terminate your participation in our certified workers compensation health care network before the policy expires. The premium reduction you received may be forfeited if we determine that you have failed to provide the notice of network requirements and employee acknowledgement form to your employees in accordance with Chapter 1305.005(d) and 1305.451 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code.

Minimum premium policies are not eligible for this premium reduction.

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

VIRGINIA AMENDATORY ENDORSEMENT

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

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

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

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

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

Endorsement Effective: Policy No.: Endorsement No.:

Insured: Premium:

Insurance Company: Countersigned by: _____

WISCONSIN LAW ENDORSEMENT

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

II. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all the terms of this policy.

IV. If any injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

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: _____

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect. If you purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.
2. We may cancel this policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:
   a. You fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;
   b. A material misrepresentation;
   c. A substantial breach of the obligations, conditions or warranties under the policy; or
   d. A substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.
3. If we cancel for any permissible reason other than non-payment of premium, we must deliver or mail, first class, not less than *thirty (30) days notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than *sixty (60) days advance written notice stating our intention not to renew this policy.
2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.
3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year, whichever is less.
4. If we offer to renew the policy on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policyholder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after the notice is mailed or delivered, in which case, you, the policyholder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and ex-tent of the risk insured against, including, but not limited to, a change in the classifications for the business.

* Any written agreement attached to and made a part of the policy, between the insurance carrier and policy holder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

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: _____

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, non-payment of loss reimbursement or non-delivery of satisfactory security or collateral when due for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

FLORIDA ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, for which we will provide at least 10 days notice, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Under no circumstances will the number of days shown below be less than 45 days.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

MISSOURI ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, non-payment of loss reimbursement or non-delivery of satisfactory security or collateral when due for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Under no circumstances will the number of days shown below be less than 60 days.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

ILLINOIS ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, or failure to cooperate with the terms and conditions of the policy for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your last known mailing address will be sufficient to prove notice.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium or failure to cooperate with the terms and conditions of the policy for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

If the policy is cancelled for nonpayment of premium, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve you by certificate of mailing advance written notice stating when the cancellation will take effect.

If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service upon you advance written notice stating when the cancellation or nonrenewal will take effect.

Under no circumstances will the number of days shown below be less than 10 days for nonpayment of premium and 30 days for any other reason

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019 01** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

WASHINGTON ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART SIX • CONDITIONS, D. – Cancellation, 2. is deleted in its entirety and replaced with:

We may cancel or non-renew this policy. We must mail or deliver to you not less than the number of days shown below advance written notice stating when the cancellation or non-renewal is to take effect.

Except for non-payment of premium, or failure to cooperate with the terms and conditions of the policy for which we will provide the advance written notice required by law, we shall not provide less than the number of days advance notice set forth below, or in the policy and endorsements attached thereto, or as required by state law.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Non-Renewal: 90 Days

All other terms and conditions of this policy remain the same.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

KNOWLEDGE OF OCCURRENCE ENDORSEMENT

This endorsement changes such insurance as is afforded by provision of the policy relating to the following:

Workers Compensation and Employers Liability Policy

PART FOUR – YOUR DUTIES IF INJURY OCCURS the following is added:

You must see to it that we are notified as soon as practicable of any injury which may result in a claim. Knowledge of an injury by your agent, your servant, or your employee will not in itself constitute knowledge to you unless the Director of Risk Management (or one with similar or equivalent title) or his/her designee, at the address shown in the policy declarations, will have received such notice.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

ARIZONA KNOWLEDGE OF OCCURRENCE ENDORSEMENT

This endorsement changes such insurance as is afforded by provision of the policy relating to the following:

Workers Compensation and Employers Liability Policy

PART FOUR – YOUR DUTIES IF INJURY OCCURS the following is added:

7. You must see to it that we are notified as soon as practicable of any injury which may result in a claim. Knowledge of an injury by your agent, your servant, or your employee will not in itself constitute knowledge to you unless the Director of Risk Management (or one with similar or equivalent title) or his/her designee, at the address shown in the policy declarations, will have received such notice.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

FLORIDA KNOWLEDGE OF OCCURRENCE ENDORSEMENT

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

PART FOUR – YOUR DUTIES IF INJURY OCCURS the following is added:

7. You must notify us as soon as practicable of any injury which may result in a claim. Knowledge of an injury by your agent, your servant, or your employee will not in itself constitute knowledge to you unless the Director of Risk Management (or one with similar or equivalent title) or his/her designee, at the address shown in the Information Page, will have received such notice.

STARR INDEMNITY
A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

Policy Number: **100 0004019** **Effective Date:** **12/31/2020**
The Insured: **MEDSPEED, LLC**

ADVANCE NOTICE OF CANCELLATION OR NON-RENEWAL EXTENDED BY US - TEXAS

This endorsement modifies insurance provided under the following:

Workers Compensation and Employers Liability Policy

The following relates to **PART SIX - CONDITIONS**:

For any statutorily permitted reason other than nonpayment of premium, nonpayment of loss reimbursement or non-delivery of satisfactory security or collateral when due, we shall not provide less than the number of days advance notice set forth below. In no event shall notice be less than the number of days required by state law.

That notice will be sent certified mail or delivered to you in person.

Mailing that notice to you, at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

Cancellation: 90 Days
Nonrenewal: 90 Days

All other terms and conditions of this policy remain the same.

Signed for by:

Steve Blakey, President and Chief Executive Officer

Nehemiah E. Ginsburg, General Counsel

STARR INDEMNITY & LIABILITY COMPANY

A MEMBER OF STARR COMPANIES

Dallas, TX 1-866-519-2522

NORTH DAKOTA AMENDATORY ENDORSEMENT
EMPLOYERS LIABILITY COVERAGE

Policy Number: 100 0004019 **Effective Date:** 12/31/2020

Named Insured: MEDSPEED, LLC

This endorsement changes such insurance as is afforded by provision of the policy relating to the following:

Workers Compensation and Employers Liability Policy

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.

We may only cancel during the term of the policy for one or more of the following reasons:

a. Nonpayment of premiums;

b. Misrepresentation or fraud made by or with the knowledge of insured obtaining the policy or in pursuing a claim under the policy;

c. Actions by the insured that has substantially increased or substantially changed the risk insured;

d. Refusal of the insured to eliminate known conditions that increase the potential for loss after notification by the insurer that the condition must be removed;

e. Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the contract;

f. Loss of reinsurance by the insurer which provided coverage to the insurer for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this subsection must advise the policyholder that the policyholder has ten days from the date of receipt of the notice to appeal the cancellation to the insurance commissioner and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within five business days after receipt of the appeal;

g. A determination by the insurance commissioner that the continuation of the policy could place the insurer in violation of the insurance laws of this state;

h. Nonpayment of dues to an association or organization, other than an insurance association or organization, when payment of dues is a prerequisite to obtaining or continuing such insurance; except this provision for cancellation for failure to pay dues

i. does not apply to persons who are retired at sixty-two years of age or older or to any person who is disabled according to social security standards; or

j. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property

All other terms, conditions and exclusions of the policy shall remain unchanged.

Signed for by:

Steve Blakey

Steve Blakey, President and Chief Executive Officer

Nehemiah E. Ginsburg

Nehemiah E. Ginsburg, General Counsel and Secretary