

A Custom Insurance Policy Prepared for:

CROSS COUNTRY HEALTHCARE INC 6551 PARK OF COMMERCE BLVD SUITE 200 BOCA RATON FL 33487



and the Market Committee of the Committe

## SAFETY SERVICES

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

## SAFETY IS OUR CONCERN

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

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

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

Following are some examples of available safety services:

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

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

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

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

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

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

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

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

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

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

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



#### SAFETY IS YOUR CONCERN

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

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

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

## **SELF-INSPECTION PROGRAM:**

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

## **SELF-INSPECTION PROGRAM (continued):**

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

### ACCIDENT INVESTIGATION:

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

## **EDUCATION AND TRAINING:**

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

WUNT3B13 Page 2 of 5

## <u>Please call these numbers</u> FOR SAFETY SERVICES ONLY

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

#### ALABAMA Birmingham

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

## CALIFORNIA San Diego

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

## HAWAII Orange, CA

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

#### ALASKA Portland, OR

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

### CALIFORNIA Walnut Creek

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

### IDAHO Portland, OR

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

#### ARIZONA Phoenix

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

#### COLORADO Denver

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

### ILLINOIS Chicago

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

#### ARKANSAS Richardson, TX

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

## CONNECTICUT Hartford

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

### ILLINOIS Naperville

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

### CALIFORNIA Diamond Bar

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

## DELAWARE

Washington, DC

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

#### INDIANA Indianapolis

Suite 300

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

## CALIFORNIA Glendale

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

## DISTRICT OF COLUMBIA Washington, DC

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

### IOWA Des Moines

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

#### CALIFORNIA Los Angeles

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

## FLORIDA Orlando

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

### KANSAS Kansas City

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

### CALIFORNIA Sacramento

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

### GEORGIA Atlanta

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

#### KENTUCKY Louisville

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

## Please call these numbers FOR SAFETY SERVICES ONLY

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

### **LOUISIANA New Orleans**

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

#### MAINE Portland, ME

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

### MARYLAND Washington, DC

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

## MASSACHUSETTS

**Boston** 

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

## **MASSACHUSETTS**

Hudson

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

#### **MASSACHUSETTS** Braintree

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

### **MICHIGAN Grand Rapids**

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

## **MICHIGAN**

Troy

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

## **MINNESOTA** St. Paul

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

## MISSISSIPPI

Jackson

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

## MISSOURI

Maryland Heights

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

### Kansas City

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

## Missouri Workers'

Compensation Plan (MWCP)

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

## **MONTANA**

Portland, OR

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

## **NEBRASKA**

Omaha

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

## **NEVADA**

Las Vegas

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

## **NEW HAMPSHIRE** Portland, ME

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

## **NEW JERSEY**

Morristown

445 South Street Morristown, NJ 07960 (973) 631-7015 Claims: 1-800-842-2475

## **NEW JERSEY**

Mariton

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

## **NEW MEXICO**

Phoenix

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

## **NEW YORK**

Albany

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

## **NEW YORK**

Buffalo

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

### **NEW YORK**

Jericho-Long Island

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

## **NEW YORK**

New York

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

## Please call these numbers FOR SAFETY SERVICES ONLY

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



### NEW YORK Rochester

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

#### NEW YORK Syracuse

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

## NORTH CAROLINA Charlotte

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

## NORTH CAROLINA Raleigh

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

### NORTH DAKOTA St. Paul, MN

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

## OHIO

## Cincinnati

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

## OHIO Cleveland

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

#### **OKLAHOMA**

### Tulsa

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

## OREGON Portland

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

### PENNSYLVANIA Philadelphia

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

### PENNSYLVANIA Pittsburgh

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

## PENNSYLVANIA

Reading

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

## RHODE ISLAND

Braintree

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

## SOUTH CAROLINA Charlotte

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

## **SOUTH DAKOTA**

St. Paul, MN

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

## TENNESSEE

Franklin

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

## TEXAS

**Dallas** 

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

#### TEXAS Houston

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

## UTAH Denver, CO

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

### VERMONT Hartford, CT

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

### VIRGINIA Richmond

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

#### Washington, DC

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

#### WASHINGTON Seattle

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

## WEST VIRGINIA

Pittsburgh, PA

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

### WISCONSIN Milwaukee

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

## WYOMING Denver, CO

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



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TYPE V

INFORMATION PAGE WC 00 00 01 ( A)

POLICY NUMBER: (TRKUB-488D360-1-13)

RENEWAL OF (TRKUB-488D360-1-12)

INSURER: THE TRAVELERS INDEMNITY COMPANY

NCCI CO CODE: 11347

INSURED:

1.

PRODUCER:

CROSS COUNTRY HEALTHCARE INC 6551 PARK OF COMMERCE BLVD SUITE 200 BOCA RATON FL 33487

LOCKTON COMPANIES LLC 444 W 47TH STREET SUITE 900

KANSAS CITY MO 64112

Insured is CORP & LLC

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

- 2. The policy period is from 08-30-13 to 08-30-14 12:01 A.M. at the insured's mailing address.
- 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

AZ MA WI

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

Bodily Injury by Accident: \$

1000000 Each Accident

Bodily Injury by Disease: \$

1000000 Policy Limit

Bodily Injury by Disease: \$

1000000 Each Employee

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

COVERAGE EXCLUDED.

**D.** This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

**DATE OF ISSUE**: 09-09-13

OFFICE: KANSAS CITY

095

PRODUCER: LOCKTON COMPANIES LLC

NA287



TYPE V INFORMATION PAGE WC 00 00 01 ( A)

POLICY NUMBER: (TRKUB-488D360-1-13)

**CLASSIFICATION SCHEDULE:** 

**PREMIUM BASIS** 

**ESTIMATED** 

RATES **PER \$100 OF**  **ESTIMATED** 

TOTAL ANNUAL

ANNUAL

CLASSIFICATIONS

CODE NO

REMUNERATION

REMUNERATION

**PREMIUM** 

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 8099

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM \$

STANDARD 109141 \$ **EXCESS** 

PREMIUM DISCOUNT

TO BE DETERMINED

NONE

0900-20 EXPENSE CONSTANT

338

TERRORISM CAT (OTHER THAN CERT ACTS OF TERRORISM)

INCLUDED

INCLUDED

TOTAL ESTIMATED PREMIUM

109141

338

TAXES AND SURCHARGES

2888

NONE

AMS BINDER BILLED # 235411

Minimum Premium: \$ 900

EMPLOYERS LIABILITY MINIMUM: \$120

DATE OF ISSUE: 09-09-13 JM

OFFICE: KANSAS CITY

095

PRODUCER: LOCKTON COMPANIES LLC

NA287

COUNTERSIGNED-AGENT



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

POLICY NUMBER: (TRKUB-488D360-1-13)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-AZ

INSURED'S NAME: CROSS COUNTRY HEALTHCARE INC

RATING MODE: RETRO

RATE BUREAU ID: 917360316

PREMIUM BASIS

ESTIMATED

RATES

**ESTIMATED** 

TOTAL ANNUAL

PER \$100 OF

ANNUAL

CLASSIFICATION

CODE

REMUNERATION

REMUNERATION

**PREMIUM** 

LOCATION 001 01

FEIN 651057354 ENTITY CD 002

CROSS COUNTRY LOCAL INC

432 N 44TH ST PHOENIX, AZ 85005

FEIN 134172686 ENTITY CD 010

METROPOLITAN RESEARCH ASSOCIATES LLC

NO BUSINESS LOCATION NONE, AZ 85034

FEIN 204967924 ENTITY CD 017

METROPOLITAN RESEARCH ASSOCIATES, INC DBA AKOS (US)

NO BUSINESS LOCATION NONE, AZ 85001

BLANKET WAIVER
SEE ENDT WC 00 03 13 (00)-001
WAIVER CALCULATION IS BASED ON
CLASS CODE(S) PREMIUM X RATE

0930

32355

.00

CLERICAL OFFICE EMPLOYEES NOC

8810

105795

.23

243

DATE OF ISSUE: 09-09-13 JM

SCHEDULE NO:

1 OF MORE



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

POLICY NUMBER: (TRKUB-488D360-1-13)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
HOSPITAL: PROFESSIONAL EMPLOYEES	8833	2414400	1 .33	32112
HOSPITAL: PROFESSIONAL EMPLOYEES	8833U	IF ANY	1.50	

LOCATION 002 01

FEIN 262936379 ENTITY CD 012

MDA HOLDING INC

NO BUSINESS LOCATION NONE, AZ 85034

FEIN 262936432 ENTITY CD 013

MEDICAL DOCTOR ASSOCIATES LLC

NO BUSINESS LOCATION NONE, AZ 85034

FEIN 383786423 ENTITY CD 014

ALLIED HEALTH GROUP LLC

NO BUSINESS LOCATION NONE, AZ 85034

FEIN 383786422 ENTITY CD 015

CREDENT VERIFICATION AND LICENSING SERVICES LLC

NO BUSINESS LOCATION NONE, AZ 85024



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

POLICY NUMBER: (TRKUB-488D360-1-13)

PREMIUM BASIS

ESTIMATED

RATES

ESTIMATED

CLASSIFICATION

CODE

TOTAL ANNUAL REMUNERATION

PER \$100 OF REMUNERATION

ANNUAL PREMIUM

LOCATION 002 01 (CONT'D)

ASYLUM: ALL OTHER EMPLOYEES

9040

IF ANY

5.01

AZ MANUAL PREMIUM \$

32355

	STANDARD	EXCESS
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 356 \$	NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	32711	NONE
EXPERIENCE MODIFICATION: 1.12 MODIFIED PREMIUM	36636	NONE
DEVIATION PROGRAM CREDIT (9034) - 20.00%	7327	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	29309	NONE
CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	NONE	NONE
TOTAL ESTIMATED PREMIUM	29309	NONE
DEPOSIT AMOUNT DUE	29309	NONE

DATE OF ISSUE: 09-09-13 JM

SCHEDULE NO:

3 OF MORE



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

POLICY NUMBER: (TRKUB-488D360-1-13)

INSURER: THE TRAVELERS INDEMNITY COMPANY

11347-MA

INSURED'S NAME: CROSS COUNTRY HEALTHCARE INC

RATING MODE: RETRO

RATE BUREAU ID: 917360316

PREMIUM BASIS

ESTIMATED

RATES

**ESTIMATED** 

TOTAL ANNUAL

PER \$100 OF

ANNUAL

CLASSIFICATION

CODE

REMUNERATION

REMUNERATION

PREMIUM

LOCATION 001 01

FEIN 043266682 ENTITY CD 003

TVCM INC

40 EASTERN AVENUE MALDEN, MA 02148

FEIN 020538692 ENTITY CD 004

CROSS COUNTRY CONSULTING INC

80 CAPITAL DR WEST SPRINGFIELD. MA 01089

FEIN 710802094 ENTITY CD 006

CLINFORCE INC

800 HINGHAM ST #103N ROCKLAND, MA 02370

FEIN 204967924 ENTITY CD 017

METROPOLITAN RESEARCH ASSOCIATES, INC. DBA AKOS (US)

NO BUSINESS LOCATION NONE, MA 02101



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

POLICY NUMBER: (TRKUB-488D360-1-13)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT/D)				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00)-001 WAIVER CALCULATION IS BASED ON CLASS CODE(S) PREMIUM X RATE	0930	75841	.02	1517
CLERICAL OFFICE EMPLOYEES NOC	8810	4901826	.09	4412
HOSPITAL: PROFESSIONAL EMPLOYEES	8833	6675635	1.07	71429
HOSPITAL: PROFESSIONAL EMPLOYEES	8833U	IF ANY	1 .41	

MA MANUAL PREMIUM \$

75841

	STANDARD	EXCESS
2.00% EMPL. LIAB. INCREASED LIMITS(9812)	\$ 1517 \$	NONE
DEVIATION PROGRAM CREDIT(9037) 25.00%	19719	NONE
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION	591 56	NONE
EXPERIENCE MODIFICATION: 1.12 MODIFIED PREMIUM	66255	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	66255	NONE
.00% ARAP MODIFICATION PROGRAM (0277)	NONE	NONE
EXPENSE CONSTANT(0900)	NONE	338
MA WC SPECIAL FUND AND TRUST FUND	2888	NONE
TOTAL ESTIMATED PREMIUM	691 43	338
DEPOSIT AMOUNT DUE	691 43	338

DATE OF ISSUE: 09-09-13 JM

SCHEDULE NO: 5 OF MORE



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

POLICY NUMBER: (TRKUB-488D360-1-13)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

13579-WI

INSURED'S NAME: CROSS COUNTRY HEALTHCARE INC

RATING MODE: RETRO

RATE BUREAU ID: 917360316

PREMIUM BASIS

ESTIMATED

RATES

**ESTIMATED** 

TOTAL ANNUAL

PER \$100 OF

ANNUAL

CLASSIFICATION

CODE

REMUNERATION

REMUNERATION

PREMIUM

LOCATION 001 01

FEIN 134066229 ENTITY CD 001

CROSS COUNTRY HEALTHCARE INC

6333 ODANA ROAD MADISON, WI 53719

FEIN 043418038 ENTITY CD 011

CEJKA SEARCH INC

NO BUSINESS LOCATION NONE, WI 53714

FEIN 770511591 ENTITY CD 016

ASSENT CONSULTING INC

NO BUSINESS LOCATION NONE, WI 53714

FEIN 204967924 ENTITY CD 017

METROPOLITAN RESEARCH ASSOCIATES, INC. DBA AKOS (US)

NO BUSINESS LOCATION NONE, WI 53562



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

POLICY NUMBER: (TRKUB-488D360-1-13)

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01 (CONT'D)				
BLANKET WAIVER SEE ENDT WC 00 03 13 (00)-001 WAIVER CALCULATION IS BASED ON				
CLASS CODE(S) PREMIUM X RATE	0930	11758	.02	235
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.27	
HOSPITAL: PROFESSIONAL EMPLOYEES	8833	1078759	1 .09	11758

LOCATION 002 01

FEIN 262936379 ENTITY CD 012

MDA HOLDING INC

NO BUSINESS LOCATION NONE, WI 53714

FEIN 262936432 ENTITY CD 013

MEDICAL DOCTOR ASSOCIATES LLC

NO BUSINESS LOCATION NONE, WI 53714

FEIN 383786423 ENTITY CD 014

ALLIED HEALTH GROUP LLC

NO BUSINESS LOCATION NONE, WI 53714

FEIN 383786422 ENTITY CD 015

CREDENT VERIFICATION AND LICENSING SERVICES LLC

NO BUSINESS LOCATION NONE, WI 53714

DATE OF ISSUE: 09-09-13 JM

SCHEDULE NO: 7 OF MORE



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

POLICY NUMBER: (TRKUB-488D360-1-13)

PREMIUM BASIS

ESTIMATED TOTAL ANNUAL

RATES

**ESTIMATED** 

CLASSIFICATION

CODE

REMUNERATION REMUNERATION

PER \$100 OF

ANNUAL PREMIUM

LOCATION 002 01 (CONT'D)

ASYLUM: ALL OTHER EMPLOYEES

9040

IF ANY

5.86

WI MANUAL PREMIUM \$ 11758

1.10% EMPL. LIAB. INCREASED LIMITS(9812) TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION EXPERIENCE MODIFICATION: 1.12 MODIFIED PREMIUM TOTAL ESTIMATED ANNUAL STANDARD PREMIUM CAT(OTHER THAN CERT ACTS OF TERRORISM) 9741	\$ STANDARD 129 12122 13577 13577 NONE	\$ EXCESS NONE NONE NONE NONE NONE
TOTAL ESTIMATED PREMIUM	13577	NONE
DEPOSIT AMOUNT DUE	13577	NONE

DATE OF ISSUE: 09-09-13 JM

SCHEDULE NO: 8 OF LAST



ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: (TRKUB-488D360-1-13)

## LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC	00	00	01	Α	-	001	INFORMATION PAGE
WC	00	00	01	Α	-	001	INFORMATION PAGE 2
WC	00	00	01	Α	-	001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC	00	00	01	Α	-	001	ENDORSEMENT LISTING
WC	48	05	06	00	-	001	WI RETRO RATING PLAN PREM ENDT-LRARO
WC	00	01	06	Α		001	LONGSHORE AND HARBOR WC ACT COVERAGE
WC	00	03	01	Α	-	001	ALTERNATE EMPLOYER ENDORSEMENT
WC	00	03	11	Α	-	001	VOLUNTARY COMP AND EMPLOYERS LIAB COV
WC	00	03	13	00	-	001	WAIVER OF OUR RIGHT TO RECOVER
WC	00	04	14	00	-	001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC	00	05	16	00	-	001	RETRO RATING PLAN PREM ENDT-LRARO
WC	99	01	01	00	-	001	STATE WC COMP LAWS AND USL & H WC ACT
WC	99	01	02	00	-	001	OPERATIONS FOR STATE & USL&H LAWS
WC	99	03	03	Α	-	001	FOREIGN REIMBURSEMENT ENDT.
WC	99	03	03	00	-	001	FOREIGN REIMBURSEMENT ENDORSEMENT
WC	99	06	03	00	-	001	GENERAL PURPOSE ENDORSEMENT
WC	99	06	10	00	-	001	AMENDED CANCELLATION CONDITION
WC	00	04	21	С	-	001	CATASTROPHE (O/T CERT. ACTS OF TERR)ENDT
WC	99	06	G7	Ε		001	FED TERRORISM RISK INS ACT DISCLOSURE
WC	00	04	19	00	-	001	PREMIUM DUE DATE ENDORSEMENT
WC	02	04	01	С	-	001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
WC	02	06	01	00	-	001	ARIZONA CANCELATION ENDORSEMENT
WC	20	03	01	00	~	001	MA LIMITS OF LIABILITY ENDORSEMENT
WC	20	03	02	Α	-	001	MASSACHUSETTS - ASSESMENT CHARGE
WC	20	03	03	D	-	001	MA NOTICE TO POLICYHOLDER ENDORSEMENT
WC	20	04	01	00	-	001	MASS PENDING PREM CHANGE ENDT
WC	20	04	05	00	-	001	MASSACHUSETTS PREMIUM DUE DATE ENDT
WC	20	06	01	Α	-	001	MA CANCELLATION ENDORSEMENT
WC	48	06	01	С	-	001	WISCONSIN LAW ENDORSEMENT
WC	48	06	03	В		001	WISCONSIN FOREIGN COVERAGE ENDT
WC	48	06	06	В	-	001	WISCONSIN CANCELLATION AND NON RENEWAL



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## The Travelers Insurance Companies

(Each a Stock Insurance Company) Hartford, Connecticut

## WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

## **GENERAL SECTION**

## A. The Policy

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

## B. Who Is Insured

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

## C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational 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.

- 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. 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:

- reasonable expenses incurred at our request, but not loss of earnings;
- 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.
- 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.
- 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.

- 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.

- 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.
- 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:

- Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
- Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
- 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;
- 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;
- 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;
- Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions.
- 8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws.
- 9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws.
- Bodily injury to a master or member of the crew of any vessel.
- 11. Fines or penalties imposed for violation of federal or state law.
- 12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

### D. We Will Defend

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

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



## E. We Will Also Pay

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

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

## F. Other Insurance

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

### G. Limits of Liability

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

 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.

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:

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

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

### PART THREE – OTHER STATES INSURANCE

## A. How This Insurance Applies

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

#### B. Notice

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



## PART FOUR - YOUR DUTIES IF INJURY OCCURS

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

- 1. Provide for immediate medical and other services required by the workers compensation law.
- 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.
- 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:

- 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:

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

### F. Records

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

## G. Audit

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



payroll and disbursement records, and programs for storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

## PART SIX - CONDITIONS

## A. Inspection

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

## B. Long Term Policy

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

## C. Transfer of Your Rights and Duties

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

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

### D. Cancellation

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

## E. Sole Representative

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

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

Wendy C. Shy

Bran Thac Clan
President



ENDORSEMENT WC 48 05 06 (OO)

POLICY NUMBER: (TRKUB-488D360-1-13)

## WISCONSIN RETROSPECTIVE RATING PLAN PREMIUM ENDORSEMENT LARGE RISK ALTERNATIVE RATING OPTION

This endorsement is added to Part Five (Premium) because you chose to have the cost of the insurance rated retrospectively. This endorsement applies only to workers compensation and employers liability insurance when rated under the provisions of the Large Risk Alternative Rating Option ("LRARO") that we have negotiated with you. Under LRARO, we and you have negotiated the components of your retrospective rating plan in accordance with your individual risk needs.

In this endorsement "you" and "your" means and includes the Named Insured of this policy or any other policies listed in the Schedule of this endorsement and each of their affiliates, divisions, subsidiaries, general partners and/or limited partners who are named insureds on any of these policies and/or who are employees referenced in Item 1 of the Information Pages of those policies. We and you have agreed that your payment obligations and other duties under this policy and under any other policies listed in the Schedule of this endorsement are joint and several in nature.

This endorsement applies because Wisconsin is listed under Item 3A of the Policy Information Page. It determines the retrospective rating plan premium for the insurance provided during the rating plan period by this policy and any policy listed in the Schedule. The rating plan is either the one year period or three year period beginning with the effective date of this endorsement.

The amount of retrospective premium depends on five standard elements and two elective elements.

## A. Retrospective Rating Plan Premium Standard Elements

- 1. Standard premium is the premium we would charge during the rating plan period if you had not chosen a retrospective rating plan. Standard premium does not include the following elements and any other elements excluded based on our manuals:
  - · Premium discount
  - Expense constant
  - Premium resulting from the nonratable element codes
  - Premium developed by the passenger seat surcharge under Classification Code 7421
  - Premium developed by the occupational disease rates for employers subject to the Federal Mine Safety and Health Act
  - Premium developed by the catastrophe provisions as outlined in our manuals

The estimated standard premium is shown in the Schedule. The final standard premium will be determined when we audit your policy.

2. Basic premium is less than standard premium. You have agreed to have your basic premium calculated either as (a.) a percentage of standard premium, (b.) a rate times an exposure base, or (c.) a flat amount. The method of calculating your basic premium is shown in the Schedule. We have estimated your basic premium and it is shown in the Schedule. The final basic premium will be determined when we calculate your retrospective premium, after your policy is audited.

The basic premium includes:

General administration costs of the carrier



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- Cost of loss control services
- Insurance charges
- · Taxes (optional)

Basic premium generally does not cover premium taxes or claims handling expenses. Those elements are usually provided for in the tax multiplier and claims handling charges. However, the insured and insurer may agree to include a charge for taxes or claim handling in the basic premium.

3. Incurred losses are all amounts we pay or estimate we will pay for losses, interests on judgments, expenses to recover against third parties, and employers liability loss adjustment expenses. This includes paid and outstanding losses (including any reserves set on open claims). Incurred losses include Allocated Loss Adjustment Expenses (ALAE).

<u>Note</u>: The rating formula for incurred losses will not include a loss for the following elements or any other elements excluded from our manuals:

- Resulting from the nonratable element codes
- Developed by the passenger seat surcharge under Classification Code 7421
- Developed by the occupational disease rates for employers subject to the Federal Mine Safety and Health Act
- Developed by the catastrophe provisions as outlined in our manuals
- 4. Claim handling charges may be calculated as either (a.) a loss conversion factor (percentage) applied to each loss, (b.) a flat amount per claim, or (c.) a flat amount against the policy. If Retrospective development factors apply (refer to B.2. below), claim handling charges determined by the loss conversion factor (percentage) will be applied to each loss including the retrospective development premium. Incurred losses to which claim handling charges have been applied are known as converted incurred losses. Claim handling charges are shown in the Schedule.
- 5. Taxes are part of the premium we collect. Taxes may be determined as a percentage of basic premium, converted incurred losses, and any elective elements. This percentage is called the tax multiplier. The tax multiplier is shown in the Schedule. The insured and insurer may agree to include taxes as part of the basic premium.

### B. Retrospective Rating Plan Premium Elective Elements

Two other elements may be included in determining retrospective rating plan premium as negotiated with you and explained below.

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

The charge for this loss limitation is called excess loss premium and may be calculated either as (a.) a percentage of standard premium, (b.) a rate times an exposure base, or (c.) a flat amount. The rate and basis used to calculate your excess loss premium is shown in the Schedule. We have estimated your excess loss premium and it is shown in the Schedule. The final excess loss premium will be determined when we calculate your retrospective premium, after your policy is audited.



**ENDORSEMENT WC 48 05 06 (OO)** 

POLICY NUMBER: (TRKUB-488D360-1-13)

2. The election of retrospective development factors used to stabilize premium adjustments means that the retrospective rating plan premium is increased by the addition of a retrospective development premium element. It is a percentage of converted incurred losses. If you chose this elective element, the retrospective development factors will be shown in the Schedule.

## C. Retrospective Rating Plan Premium Formula

Insurance policies listed in item 4. of the Schedule will be combined with this policy to calculate the retrospective rating plan premium. If the policies provide insurance for more than one insured, the retrospective premium will be determined for all insureds combined, not separately, for each insured.

- Retrospective rating plan premium is the sum of basic premium, incurred losses, claim handling charges, retrospective development premium (if elected), taxes, plus the excess loss premium elective element, depending on the options that we have negotiated with you.
- 2. The retrospective rating plan premium will not be less than the minimum, nor more than the maximum retrospective rating plan premium agreed to by you and us. The method of calculating the minimum and maximum retrospective rating plan premium amounts is shown in the Schedule.
  - As an alternative to a maximum retrospective plan premium, you may agree to a maximum loss content which may apply across multiple lines and/or multiple policies. Under this arrangement the maximum amount of payments by you for any reimbursement within a deductible (states other than Wisconsin), loss limit, or retained limit for any policy listed in the Schedule, shall be limited to the amount specified as the maximum loss content in that Schedule. The insured and insurer may agree to state the maximum loss content as a negotiated rate per \$100 of final audited payroll, or other exposure base specified on the Schedule, subject to a negotiated minimum aggregate. As an alternative, the insured and insurer may also agree to state maximum loss content as a negotiated percentage of final audited standard premium.
- 3. Insurance policies listed in the Schedule will be combined with this policy to calculate standard premium which will be the sum of the standard premium for each policy and State.

## D. Calculation of Retrospective Rating Plan Premium

- 1. We will calculate the retrospective rating plan premium using all loss information we have as of a date six months after the rating plan period ends and annually thereafter.
  - We may make a special valuation of a retrospective rating plan premium as of any date that you are declared bankrupt or insolvent, make an assignment for the benefit of creditors, are involved in reorganization, receivership, or liquidation, or dispose of all your interest in work covered by the insurance.
- 2. After any calculation of retrospective rating plan premium, you and we may agree that it is the final calculation.
- 3. After each calculation of the retrospective rating plan premium, you will promptly pay any amount due us, or we will refund the amount due you.
- 4. We will make interim calculations of retrospective premium in the first year and first two years of a three-year rating plan, unless we and you agree not to make such interim calculations. For the first year interim calculation, we will use losses as of a date mutually agreed to by you and us. The interim calculation for the first two years will be one year after the first year interim calculation.
- 5. We and you have agreed that in the event you fail to meet any payment obligation or you fail to satisfy any other requirement under this policy or under any other policies listed in the Schedule of this endorsement, we shall be entitled to, among other remedies available to us, consider due and payable all





ENDORSEMENT WC 48 05 06 (OO)

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of your payment obligations to us including, but not limited to, those payment obligations accruing in the future.

## E. Cancellation of a Policy Under a Retrospective Rating Plan

- 1. If the policy to which this endorsement is attached is cancelled, the effective date of cancellation will become the end of the rating plan period for all insurance subject to this endorsement.
- 2. If other policies listed in the Schedule of this endorsement are cancelled, the effective date of cancellation will become the end of the rating plan period for all insurance subject to this endorsement unless we agree with you, by endorsement, to continue the rating plan period.
- 3. If, as a condition of this program, a requirement to post collateral to secure your payment obligations to us has been negotiated between you and us, your failure to deliver to us or to continue to maintain or to increase any such required collateral or any renewal, replacement or amendment thereof shall mean that we shall be entitled to, among other remedies available to us, cancel this policy and/or other policies listed in the Schedule of this endorsement. If collateral to secure your payment obligations has been negotiated between you and us, all such collateral will secure all payment obligations in connection with this policy and any other policy listed in the Schedule of this endorsement, as well as any renewals of those policies. Any deductible policies listed in the Schedule do not apply to Wisconsin losses.
- 4. If we cancel for nonpayment of premium, the maximum retrospective rating plan premium will be based on the standard premium for the rating plan period, increased pro rata to 365 days, for a one year plan and 1095 days for a three year plan, and will include all of the applicable retrospective plan factors shown in the Schedule.
- **5.** If you cancel, the standard premium for the rating plan period will be increased by our short rate table and procedure. The minimum retrospective rating plan premium is shown in the Schedule.
  - The maximum retrospective rating plan premium will be based on the standard premium for the rating plan period increased pro rata to either 365 days for a one year plan or 1095 days for a three year plan.
- 6. Section 4 above will not apply if you cancel because:
  - All work covered by the insurance is completed
  - All interest in the business covered by this insurance is sold
  - You retire from all business covered by the insurance.

DATE OF ISSUE: 09-09-13 ST ASSIGN: Page 4 of 7



**ENDORSEMENT WC 48 05 06 (OO)** 

POLICY NUMBER: (TRKUB-488D360-1-13)

## **SCHEDULE**

Term o	of Plan: a. ☒ One Year b. ☐ Three Year						
Effecti	ve Date of Plan: <u>8-30-2013</u>						
Loss L	imitation Amount: \$ 350,000						
Other	policies subject to this Retrospective Rating Plan Premium	Endorsement:					
Total E	Estimated Standard Premium: a. \$ 13,577	Wisconsin					
	<b>b.</b> \$ 2,037,014	All States					
Basic	Premium: (option that applies is indicated by 'X')						
а. 🗌	Negotiated percentage of Standard Premium:	%					
b. X	Negotiated rate of \$0.0097 per \$100 of						
	AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLISTIC STATES PAYROLL						
	subject to a minimum of \$ 15,974						
c. 🗌	Negotiated amount of \$						
Estima	ated Basic Premium \$16,815						
Exces	s Loss Premium: (if applicable; option that applies is indicat	ed by 'X')					
a. 🗌							
b. X							
	AUDITED TOTAL WC PAYROLL EXCLUDING MONOPOLI PAYROLL	STIC STATES					
	subject to a minimum of \$ 55,002						
c. 🗌	Negotiated amount of \$						
Estima	ated Excess Loss Premium \$ 57,897						
Claim	Handling Charges: (option that applies is indicated by 'X')						
a. 🗌	Negotiated loss conversion factor of applie	s to the					
	first \$ of each loss						
b. X	Negotiated per claim charge(s) of						
	\$ 160 CM; \$1,250 CB	per claim					
c. 🗌	Negotiated amount of \$						
Tax M	1 000						
	ultiplier: 1.000 applies to (option that applies is in	ndicated by 'X')					
а. 🗌	ultiplier: 1 .000 applies to (option that applies is in Basic premium and converted incurred losses	ndicated by 'X')					



ENDORSEMENT WC 48 05 06 (OO)

POLICY NUMBER: (TRKUB-488D360-1-13)

10.	Retrosp	pective Loss Development Factors: (if applicable)
		1st valuation 18 months
		2nd valuation 30 months
		3rd valuation 42 months
		4th valuation 54 months
		5th valuation 66 months
		6th valuation 78 months
		7th valuation 90 months
11.	Minimu	m Retrospective Rating Plan Premium: (option that applies is indicated by 'X')
	a. 🛚	Basic Premium plus Tax plus Excess Loss Premium, if selected
	b. 🗌	Negotiated percentage of Standard Premium:%
	c. 🗌	Negotiated rate of per \$100 of
		subject to a minimum of \$
	d. 🗌	Negotiated amount of \$
	_	<del></del>
12.		um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')
12.		<del></del>
12.	Maxim	um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')
12.	Maxim a. □	um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%
12.	Maxim a. □	um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%
12.	Maxim a. □	um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%
12.	Maxim a. □	um Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of
12.	Maxim a.  b.	num Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of  subject to a minimum of \$
	Maxim a. □ b. □ c. □ d. ☒	num Retrospective Rating Plan Premium: (option that applies is indicated by 'X')  Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of  subject to a minimum of \$  Negotiated amount of \$
	Maxim a. □ b. □ c. □ d. ☒	Negotiated rate of per \$100 of subject to a minimum of \$ Negotiated amount of \$ No Maximum Retrospective Rating Plan Maximum Premium applies
	Maxim a.  b.  c.  d.  Maxim	Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of  subject to a minimum of \$  Negotiated amount of \$  No Maximum Retrospective Rating Plan Maximum Premium applies  um Loss Content: (applicable only if 12.d.of this Schedule is selected)
	Maxim a.  b.  c.  d.  Maxim	Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of  subject to a minimum of \$  Negotiated amount of \$  No Maximum Retrospective Rating Plan Maximum Premium applies  um Loss Content: (applicable only if 12.d.of this Schedule is selected)
	Maxim a.  b.  c.  d.  Maxim	Negotiated percentage of Standard Premium:
	Maxim a.  b.  c.  d.  Maxim	Negotiated percentage of Standard Premium:%  Negotiated rate of per \$100 of  subject to a minimum of \$  Negotiated amount of \$  No Maximum Retrospective Rating Plan Maximum Premium applies  um Loss Content: (applicable only if 12.d.of this Schedule is selected)  Negotiated rate of per \$100 of
	d. X Maxim	Negotiated percentage of Standard Premium:



ENDORSEMENT WC 48 05 06 (OO)

POLICY NUMBER: (TRKUB-488D360-1-13)

Schedule of Policy Numbers for which the maximum loss content is applicable (Any deductible policies listed in the Schedule do not apply to Wisconsin losses.)

NO MAXIMUM LOSS CONTENT

**APPLIES** 

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

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

Endorsement Effective Insured

Policy No.

Endorsement No.

Premium

Insurance Company

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

DATE OF ISSUE: 09-09-13

ST ASSIGN:

Page 7 of 7





ENDORSEMENT WC 00 01 06 (A) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

## LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT COVERAGE ENDORSEMENT

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

## C. Workers' Compensation Law

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

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

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

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

## **SCHEDULE**

State	Longshore and Harbor Workers' Compensation Act Coverage Percentage
AZ	13.00
MA	32.00
WI	64.00



# WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 00 03 01 (A) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

## 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 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**

1.	Alte	emate Emplo		
	AS	REQUIRED	BY	CONTRACT

Address

- 2. State of Special or Temporary Employment
- 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
Insured	

Policy No.

Endorsement No.

Premium \$

Insurance Company

Countersigned by

DATE OF ISSUE: 09-09-13

ST ASSIGN:

Page 1 of 1



ENDORSEMENT WC 00 03 11 (A) -

POLICY NUMBER: (TRKUB-488D360-1-13)

## 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.

- 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.
- 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



#### ENDORSEMENT WC 00 03 11 (A)-

POLICY NUMBER: (TRKUB-488D360-1-13)

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 NOT SUBJECT
TO THE WORKERS'
COMPENSATION LAW

ALL STATES
EXCEPT WI
DESIGNATED WORKERS
COMPENSATION LAW

DESIGNATED WORKERS
COMPENSATION LAW





ENDORSEMENT WC 00 03 13 (00)-01

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

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

#### **SCHEDULE**

#### **DESIGNATED PERSON:**

#### **DESIGNATED ORGANIZATION:**

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

DATE OF ISSUE: 09-09-13



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

POLICY NUMBER: (TRKUB-488D360-1-13)

#### NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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



DATE OF ISSUE: 09-09-13



ENDORSEMENT WC 00 05 16 (00)

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

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

(The information be	elow is required only when this	s endorsement is issued subs	sequent to preparation of
the policy.)			

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

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



ENDORSEMENT WC 99 01 01 (00) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

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

STATE	PERCENTAGE	STATE	PERCENTAGE
AZ	13.00	WI	64.00





# WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 99 01 02 (00) 001

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

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

STATE PERCENTAGE STATE PERCENTAGE
MA 32.00

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

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

**Endorsement Effective** 

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by

DATE OF ISSUE: 09-09-13

ST ASSIGN:

Page 1 of 1



ENDORSEMENT WC 99 03 03 (A) - 001

POLICY NUMBER: (TRKUB-488D360-1~13)

#### FOREIGN REIMBURSEMENT COVERAGE ENDORSEMENT

This endorsement adds Foreign Reimbursement Insurance coverage to the policy.

A. How This Insurance Applies.

This insurance applies only 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 who is a United States citizen or a resident of the United States and described in item 1 of the Schedule.
- 2. The bodily injury must arise out of and in the course of employment necessary or incidental to work at a location described in item 2 of the Schedule, or occur while being transported to or from the United States or Canada in connection with such employment.
- 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. Bodily injury includes endemic disease.

#### B. Exclusions

This insurance does not cover:

- 1. Any duty imposed by a workers compensation or occupational disease law, or any similar law;
- 2. Bodily injury which occurs within the United States of America, its territories or possessions, or Canada;
- 3. Bodily injury sustained by a master or member of the crew of any vessel;
- 4. Bodily injury intentionally caused or aggravated by you;
- 5. Fines or penalties

#### C. Payment Conditions

We will reimburse you an amount equal to the compensation benefits that you would be required to pay to an employee who sustains a bodily injury to which this insurance applies.

Before we reimburse you, the person entitled to the benefits must:

- 1. Release you and us, in writing, of all responsibility for the injury or death.
- 2. Transfer to us the 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 our right to recover from others.

If the persons entitled to the benefits fail to do these things, our duty to reimburse you ends at once. If they claim damages from you or from us for the injury or death, our duty to reimburse you ends at once.

#### D. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits 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 benefit we paid them.





ENDORSEMENT WC 99 03 03 (A) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

#### E. Company Option

We may, at our option, pay on your behalf the benefits provided by this insurance.

#### F. Repatriation Expense

We agree to reimburse you for all reasonable expenses incurred in excess of normal transportation costs for repatriation of such employee (including the body of such employee if fatally injured) from the location of operations to the destination in the United States or Canada. The limit of our liability for such expense shall not exceed the Repatriation Expense amount stated in item 4 of the Schedule.

#### G. Part Two (Employers Liability Insurance)

The provisions of the policy applicable to Part Two (Employers Liability Insurance) are amended to apply to any injury to which Foreign Reimbursement Coverage applies, subject to the following additional provisions:

- 1. The limit of liability stated in item 3b of the Policy Information Page is replaced by the amount stated in item 4 of the Schedule as applicable to the Limit of Liability for Employers Liability Insurance;
- 2. If claim is made or suit is brought elsewhere than within the United States of America, its territories or possessions, or Canada, we shall have the right, but not the duty, to investigate and settle such claims and defend such suits. In any case in which we elect not to investigate, settle or defend, you, under supervision from us, shall make or cause to be made such investigation and defenses as are reasonably necessary, and, subject to prior authorization by us, will effect to the extent possible such settlement or settlements as we and you deem prudent. We shall reimburse you for the reasonable cost of such investigation and defense and, within the applicable limit of liability of the policy, for the amounts of such authorized settlements

#### H. Limits of Liability

The limit of liability stated in item 4 of the Schedule is the total limit of our liability for all sums payable under Foreign Reimbursement Coverage

The total limit of our liability because of bodily injury sustained by any one employee shall not exceed the lesser of:

- 1. The amount equal to the compensation and other benefits which would have been payable under the workers compensation law of the state designated in item 3 of the Schedule if such law had been applicable to such bodily injury, or
- 2. The amount designated in item 4 of the Schedule as applicable to "each employee."



#### ENDORSEMENT WC 99 03 03 (A) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

#### SCHEDULE

ITEM

1. DESIGNATED EMPLOYEES:

ALL EMPLOYEES OF THE NAMED INSURED WHILE WORKING OUTSIDE OF THE UNITED STATES

2. LOCATION AND DESCRIPTION OF OPERATIONS:

ANYWHERE IN THE WORLD

(SEE BELOW FOR DESCRIPTION)\*

COUNTRY

3. DESIGNATED WORKERS COMPENSATION LAW:

STATE

STATE OF HIRE

4. LIMITS OF LIABILITY:

EMPLOYERS LIABILITY COVERAGE BODILY INJURY BY ACCIDENT BODILY INJURY BY DISEASE	\$1,000,000 \$1,000,000	EACH ACCIDENT POLICY LIMIT
BODILY INJURY BY DISEASE FOREIGN REIMBURSEMENT COVERAGE	\$1,000,000	EACH EMPLOYEE
BODILY INJURY BY ACCIDENT BODILY INJURY BY DISEASE BODILY INJURY BY DISEASE	\$ 350,000 \$ 350,000 \$ 350,000	EACH ACCIDENT POLICY LIMIT EACH EMPLOYEE
REPATRIATION EXPENSE	\$ 50,000	EACH EMPLOYEE

\*DESCRIPTION OF OPERATIONS:

CLASSIFICATION OF OPERATIONS	CODE NO.	TOTAL ANNUAL REMUNERATION	\$100 OF REMUNERATION	ANNUAL PREMIUMS
EMPLOYEES WITH OVERSEAS RESPONSIBILITIES		\$ IF ANY	INCLUDED	\$

TOTAL ESTIMATED ANNUAL PREMIUM: \$

INCL

DATE OF ISSUE: 09-09-13



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

POLICY NUMBER: (TRKUB-488D360-1-13)

#### FOREIGN REIMBURSEMENT COVERAGE ENDORSEMENT

This endorsement adds Foreign Reimbursement Insurance coverage to the policy.

#### A. How This Insurance Applies.

This insurance applies only 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 who is a United States citizen and described in item 1 of the Schedule.
- 2. The bodily injury must arise out of and in the course of employment necessary or incidental to work at a location described in item 2 of the Schedule, or occur while being transported to or from the United States or Canada in connection with such employment.
- 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. Bodily injury includes endemic disease.

#### **B.** Exclusions

This insurance does not cover:

- 1. Any duty imposed by a workers compensation or occupational disease law, or any similar law;
- 2. bodily injury which occurs within the United States of America, its territories or possessions, or Canada.
- 3. bodily injury sustained by a master or member of the crew of any vessel;
- 4. bodily injury intentionally caused or aggravated by you;
- 5. fines or penalties.

#### C. Payment Conditions

We will reimburse you an amount equal to the compensation benefits that you would be required to pay to an employee who sustains a bodily injury to which this insurance applies.

Before we reimburse you, the person entitled to the benefits must:

- 1. Release you and us, in writing, of all responsibility for the injury or death.
- 2. Transfer to us the 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 our right to recover from others.

If the persons entitled to the benefits fail to do these things, our duty to reimburse you ends at once. If they claim damages from you or from us for the injury or death, our duty to reimburse you ends at once.

#### D. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits 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 benefit we paid them.

#### E. Company Option

We may, at our option, pay on your behalf the benefits provided by this insurance.



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

POLICY NUMBER: (TRKUB-488D360-1-13)

#### F. Repatriation Expense

We agree to reimburse you for all reasonable expenses incurred in excess of normal transportation costs for repatriation of such employee (including the body of such employee if fatally injured) from the location of operations to the destination in the United States or Canada. The limit of our liability for such expense shall not exceed the Repatriation Expense amount stated in item 4 of the Schedule.

#### G. Part Two (Employers Liability Insurance)

The provisions of the policy applicable to Part Two (Employers Liability Insurance) are amended to apply to any injury to which Foreign Reimbursement Coverage applies, subject to the following additional provisions:

- 1. The limit of liability stated in item 3b of the Policy Information Page is replaced by the amount stated in item 4 of the Schedule as applicable to the Limit of Liability for Employers Liability Insurance;
- 2. If claim is made or suit is brought elsewhere than within the United States of America, its territories or possessions, or Canada, we shall have the right, but not the duty, to investigate and settle such claims and defend such suits. In any case in which we elect not to investigate, settle or defend, you, under supervision from us, shall make or cause to be made such investigation and defenses as are reasonably necessary, and, subject to prior authorization by us, will effect to the extent possible such settlement or settlements as we and you deem prudent. We shall reimburse you for the reasonable cost of such investigation and defense and, within the applicable limit of liability of the policy, for the amounts of such authorized settlements.

#### H. Limits of Liability

The limit of liability stated in item 4 of the Schedule is the total limit of our liability for all sums payable under Foreign Reimbursement Coverage.

The total limit of our liability because of bodily injury sustained by any one employee shall not exceed the lessor of:

- The amount equal to the compensation and other benefits which would have been payable under the
  workers compensation law of the state designated in item 3 of the Schedule if such law had been
  applicable to such bodily injury, or
- The amount designated in item 4 of the Schedule as applicable to "each employee".





#### WORKERS COMPENSATION AND **EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 99 03 03 (00)**

POLICY NUMBER: (TRKUB-488D360-1-13)

#### **SCHEDULE**

#### ITEM

DESIGNATED EMPLOYEES:

\*\*\* SEE BELOW

2. LOCATION AND DESCRIPTION OF OPERATIONS: (SEE BELOW FOR DESCRIPTION)\* ANYWHERE IN THE WORLD

COUNTRY

3. DESIGNATED WORKERS COMPENSATION LAW: STATE OF HIRE

STATE

4. LIMITS OF LIABILITY:

EMPLOYERS LIABILITY COVERAGE

\$1,000,000 POLICY LIMIT

FOREIGN REIMBURSEMENT COVERAGE

\$350,000

EACH EMPLOYEE

\$1,000,000 AGGREGATE

REPATRIATION EXPENSE

\$50,000

**EACH EMPLOYEE** 

\*DESCRIPTION OF OPERATIONS:

CLASSIFICATION

CODE

**ESTIMATED** TOTAL ANNUAL RATES PER \$100 OF

**ESTIMATED** 

OF OPERATIONS

NO.

REMUNERATION

ANNUAL

REMUNERATION

**PREMIUM** 

EMPLOYEES WITH OVERSEAS

IF ANY

\$

RESPONSIBILITIES

\* ALL EMPLOYEES OF THE NAMED

INSURED WHILE WORKING OUTSIDE

OF THE UNITED STATES.

**EMPLOYERS - LIABILITY - %** 

INCREASED LIMITS (IF ANY) INCREASED LIMIT PREMIUM INCLUDED

TOTAL \$

FOREIGN REIMBURSEMENT-CHARGE (MULTIPLY BY .25)

REPATRIATION EXPENSE-INCREASE LIMITS (IF ANY)

ESTIMATED ANNUAL STANDARD PREMIUM \$

5. MINIMUM PREMIUM:

TOTAL ESTIMATED ANNUAL PREMIUM \$ INCL.

DATE OF ISSUE: 09-09-13

ST ASSIGN:

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ENDORSEMENT WC 99 06 03 (00)- 01

POLICY NUMBER: (TRKUB-488D360-1-13)

#### **GENERAL PURPOSE ENDORSEMENT**

STATE APPLICABLITY

FOREIGN REIMBURSEMENT WC 48 06 03 ( B) - WI WC 99 03 03 (00) - MA WC 99 03 03 ( A) - AZ



DATE OF ISSUE: 09-09-13 ST ASSIGN:

Page 1 of LAST



ENDORSEMENT WC 99 06 10 (00) - 001

POLICY NUMBER: (TRKUB-488D360-1-13)

#### AMENDED CANCELLATION CONDITION ENDORSEMENT

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

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

**SCHEDULE** 

NUMBER OF DAYS

90

DATE OF ISSUE: 09-09-13



ENDORSEMENT WC 00 04 21 (C)

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

For purposes of this endorsement, the following definitions apply:

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

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

#### Schedule

State	Rate	Premium

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

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

Endorsement Effective

Policy No.

Endorsement No.

Insured

Premium \$

Insurance Company

Countersigned by

DATE OF ISSUE: 09-09-13

ST ASSIGN:

Page 1 of 1



#### **WORKERS COMPENSATION** AND

**EMPLOYERS LIABILITY POLICY** 

ENDORSEMENT WC 99 06 G7 ( E)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### FEDERAL TERRORISM RISK INSURANCE ACT DISCLOSURE

This endorsement applies only to your Workers Compensation Benefit obligations.

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

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

Except as disclosed in state specific changes endorsements:

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

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

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

Endorsement Effective	Policy No.	Endorsement No.
Endoisement Enective	Folicy No.	Litadisement No.
Insured		Premium \$
Insurance Company	Countersigned by	



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

POLICY NUMBER: (TRKUB-488D360-1-13)

#### 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.





ENDORSEMENT WC 02 04 01 ( C)

POLICY NUMBER: (TRKUB-488D360-1-13)

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

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

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

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

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

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

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



#### ENDORSEMENT WC 02 04 01 ( C)

POLICY NUMBER: (TRKUB-488D360-1-13)

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



This endorsement changes the policy to which it	is attached and is effective or	the date issued unles	s otherwise
stated.			

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

Endorsement	Effective
Insured	

Policy No.

Endorsement No. Premium

Insurance Company

Countersigned by

DATE OF ISSUE: 09-09-13

ST ASSIGN:

Page 2 of 2



ENDORSEMENT WC 02 06 01 (00)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### ARIZONA CANCELATION ENDORSEMENT

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

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

#### D. Cancelation

- 1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
- 2. We may cancel this policy if you fail to pay premium when due. We must mail or deliver to you and the Industrial Commission of Arizona not less than thirty days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
- 3. The policy period will end on the day and hour stated in the cancelation notice.

DATE OF ISSUE: 09-09-13



ENDORSEMENT WC 20 03 01 (00)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because Massachusetts is listed in item 3.A of the Information Page.

Our liability to you under Section 25 of Chapter 152 of the General Laws of Massachusetts is not subject to the limit of liability that applies to Part Two (Employers Liability Insurance).



DATE OF ISSUE: 09-09-13



ENDORSEMENT WC 20 03 02 (A)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### MASSACHUSETTS - ASSESSMENT CHARGE

Massachusetts General Laws, Chapter 152, Section 65, as amended by Chapter 572 of the Acts of 1985, establishes a workers compensation special fund and a workers compensation trust fund.

On behalf of the Department of Industrial Accidents (DIA), the insurance company providing workers compensation coverage is required to bill and collect an assessment charge covering the special and trust funds from insured employers and remit the amounts collected to the State Treasury.

The assessment charge, which is determined by applying a rate (subject to annual change) to the **DIA's** standard premium, **as defined and outlined in 452 CMR 7.00**, developed under your policy, is shown as a separate item on the information page of the policy. The rate may be different for private employers and for the Commonwealth and its political subdivisions.

The income derived from the assessment charge will be used to fund the operating expenses of the DIA and to fund certain employee benefits as described in Chapter 152.

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

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

Endorsement Effective Insured

Policy No.

Endorsement No. Premium \$

Insurance Company

Countersigned by



ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Massachusetts 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 your agent or us.

You may obtain pertinent rating information by submitting a written request to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this endorsement or to us at our company 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 classification, rates, premiums or audit results were determined. If we fail to grant or reject your request within thirty days after it is made or if you are not satisfied by the results of our review, you may submit a written request for review to the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") at the address shown in this endorsement. If the WCRIBMA fails to grant or reject your request within thirty days after it is made or if you are not satisfied with the results of the WCRIBMA review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

#### 2. Reserve or Settlements

You may request a loss run, which contains reserve and settlement information for claims that relate to the premium for this policy. Such a request must be in writing and should be sent to our address shown on this endorsement. We will provide you with that information within thirty (30) days of receipt of your request, and at reasonable intervals thereafter.

If you have any questions or believe that we set unreasonable reserves or made unreasonable settlements that affected your premiums or losses, you may make a written request through your agent or directly to us for a meeting with our company representative. If you are not satisfied with the results of the meeting, you may make a written appeal to the Insurance Commissioner at the address shown on the endorsement.

#### Named Insured

You are responsible for immediately reporting all changes in name or legal status to us in writing at the company address shown in this Endorsement.

If you want to add a named insured or replace the named insured with another legal entity on any policy issued through the Massachusetts Assigned Risk Pool you must submit a new Assigned Risk Pool Application, including a Confidential Request for Information Form (ERM), to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this Endorsement

#### 4. Insured's Mailing Address

Notices relating to this Policy will be mailed or delivered to your mailing address. Your mailing address is that which is shown in Item 1 of the Information Page or in a change of address Endorsement to the Policy. You are responsible for notifying us in writing at the company address shown in this Endorsement about any change to your mailing address.

DATE OF ISSUE: 09-09-13 ST.



#### ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER: (TRKUB-488D360-1-13)

Addresses

The Workers' Compensation Rating and Inspection Bureau of Massachusetts Attention: Customer Service Department 101 Arch Street, 5th Floor Boston, MA 02110 www.wcribma.org

Commissioner of Insurance
Division of Insurance
Department of Banking and Insurance
1000 Washington St 8th Floor
Boston, MA 02118-2218

Address Correspondence as follows:

Policies with a 6NUB or 7UB in their symbol, to: Travelers Insurance Company P.O. Box 3556 Orlando, Florida 32802-3556

Policies with a 6S59UB in their symbol, to: Direct Assignment Operations P.O. Box 4965 Orlando, Florida 32802-4965 Policy with a 6ZZUB in their symbol, to: Direct Assignment Operation P.O. Box 4964 Orlando, Florida 32802-4964

Policy with a 6S6OUB in their symbol, to: Direct Assignment Operation P.O. Box 4903 Orlando, Florida 32802-4903

ALL OTHER POLICIES, TO: The Travelers Insurance Company P.O. Box 9203 Westwood, MA 02090-9203



ENDORSEMENT WC 20 04 01 (00)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### MASSACHUSETTS PENDING PREMIUM CHANGE ENDORSEMENT

A filing is being considered by the Massachusetts Division of Insurance which may result in premiums different from those shown on the policy. If it does, we will issue an endorsement to show the new premiums and their effective date.



**DATE OF ISSUE: 09-09-13** 



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 20 04 05 (00)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

Section D of Part Five of the Policy is replaced by this provision:

PART FIVE PREMIUM

**D. Premium Payments** 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 audit and retrospective premiums shall be paid by the due date indicated on the billing statement.



ENDORSEMENT WC 20 06 01 (A)

POLICY NUMBER: (TRKUB-488D360~1-13)

#### MASSACHUSETTS CANCELLATION ENDORSEMENT

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

The Cancellation Condition of the policy is replaced by the following:

#### Cancellation

- 1. You may cancel this policy by mailing or delivering to us advance written notice requesting cancellation. Such cancellation shall not be effective until ten days after written notice is given by us to The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.
- 2. We may cancel this policy only if based on one or more of the following reasons: (i) nonpayment of premium; (ii) fraud or material misrepresentation affecting your policy; or (iii) a substantial increase in the hazard insured against. Such cancellation shall not be effective until ten days after written notice is given by us to you and The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.
- 3. We will mail or deliver the notice of cancellation to you at your last address, which shall be the mailing address shown in Item 1 of the Information Page or the change of mailing address shown in an Endorsement to the Policy. Pursuant to M.G.L. Chapter 175, Section 187C, a written notice of cancellation shall be deemed effective when mailed by us if we obtain a certificate of mailing receipt from the United States Postal Service showing your name and address as stated in the policy.
- 4. Any of these provisions that conflict with the law that controls the cancellation of this insurance policy is changed by this statement to comply with the law.

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

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

Endorsement	Effective
Insured	

Policy No.

Endorsement No. Premium \$

Insurance Company

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

DATE OF ISSUE: 09-09-13



# WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 48 06 01 ( C)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### 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:

- 1. 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.

DATE OF ISSUE: 09-09-13



#### WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 48 06 03 (B)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### FOREIGN COVERAGE ENDORSEMENT

This endorsement supersedes any other Foreign Coverage Endorsement attached to this policy as respects Wisconsin employees. Foreign Coverage for Wisconsin employees is provided under Part One of the policy, at no additional charge.







# WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: (TRKUB-488D360-1-13)

#### 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 policy holder, 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.

DATE OF ISSUE: 09-09-13 ST



# WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: (TRKUB-488D360-1-13)

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 written notice is mailed or delivered, in which case, you, the policy holder, 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 extent 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 policyholder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.



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#### If Your Employee Is Injured At Work

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

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

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

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

# Promptly report your work-related injuries to Travelers: Travelers.com 800-832-7839 Learn about Travelers unique Claim Services and find a convenient medical network provider by logging on to Travelers.com. To get to Travelers website, select Business Insurance from the home page. Then choose Workers' Compensation & Managed Care Claim Management from the menu of services in the left margin. Finally, click on Preferred Provider Network to search for a Medical Network Provider near you.

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#### NOTICE TO EMPLOYEES

Longshore and Harbor Workers' Compensation Act

#### U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs



(Employer) CROSS COUNTRY HEALTHCARE INC

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

### WHAT TO DO WHEN INJURED AT WORK

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

Insurance Carrier for This Employer	For Further Assistance and Information  On request, the Office of Workers' Compensation Programs will explain benefits and	
Name the travelers insurance companies		
Address ONE TOWER SQUARE HARTFORD, CT 06183	proceedings under the above Act. In addition, the Office of Workers' Compensation Programs will inform employees receiving compensation about medical and vocation-	
Telephone 800 832-7839	al rehabilitation services, and will assist in obtaining such services.	
Policy Number (TRKUB-488D360-1-13)	Expiration Date of Policy 08-30-14	

Authorized Signature for the Employer

Date Signed

This Notice must be posted and maintained in a conspicuous place in and about the place of business. (33 U.S.C. 934)

#### **Important Notice**

Section 31(a)(1) of the Longshore Act, 33 U.S.C. 931(a)(1), provides as follows: Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed \$10,000, by imprisonment not to exceed five years, or by both.

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# WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms.

DO NOT D	ELAY IN CALI						LL THE C	QUESTIONS.	
		ACCOUN			DRMATI	ION			
CALLER'S PHONE NUMBER/EXTENSION ( )	CALLER'S TITLE		CALLER'S	NAME					REPORTING STATE
SUBSIDIARY NAME	SUBSIDIARY'S A	ADDRESS (STRI	EET, CITY, S	STATE & ZIF	P)	SUBSIDIA		NG ADDRESS (	STREET, CITY, STATE & ZIP)
DID THE ACCIDENT OCCUR AT THE LOCAT	ION ADDRESS?					LJ SAIVII	E		
YES NO IF NO, ADDRESS V	VHERE ACCIDENT	LOCCURRED							
PARENT COMPANY/INSURED'S NAME	TILLICE HOODEN	T COCOTTALED							
LOCATION CODE	POLICY SYMBO	L AND NUMBER	₹			NATURE	OF BUSINE	SS	
DATE OF INJURY				TIME OF I	NJURY	1			
ACCIDENT DESCRIPTION									
		EMP	LOYEE I	NFORMA	NOITA				
INJURED EMPLOYEE'S SOCIAL SECURITY	NUMBER	EMPLOYEE	S NAME (FII	RST, MI, LA	ST)				GENDER
									☐ MALE ☐ FEMALE
DATE OF BIRTH	EMPL	OYEE'S MAILIN	IG ADDRES	S					
EMPLOYEE'S HOME PHONE NUMBER	FMPI	OYEE'S HOME	ADDRESS	/IE DIEEER	-NT FROM	A MAII INGN			
( )		OTELOTIONE	713511200	(II DII I EIKE	_111111011	п минено)			
		EMPLO	YEE JOI	B INFOR	MATION	V .			* * ***
EMPLOYMENT STATUS CODE				ED WORKE			R	EGULAR OCCU	PATION
☐ FULL-TIME ☐ PART-TIME ☐	OTHER								
OCCUPATION WHEN INJURED			'						
EMPLOYEE'S WORK SCHEDULE									
REGULAR WORK HOURS				HOURS	/DAY			DAYS/W	EEK
EMPLOYEE'S WAGE INFORMATION	SAMPLAL OF A	6.8.17		0./507					
\$/HOUR OR \$/i  DATE OF HIRE OR LENGTH OF EMPLOYME			EEKLY	OVERII	ME: \$		AUDIII	ONAL BENEFIT:	S: \$
DATE OF TIME ON ELINGTICOT LIMPEOTINE	7141								
SUPERVISOR'S NAME			SUPE	RVISOR'S F	PHONE NU	JMBER:		BEST HOU	JRS TO CONTACT
			( )						
		ACC	IDENT IN	NFORMA	TION			I	
DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYE	E LOSE ANY T	IME FROM \	WORK?	IS THE E	MPLOYEE	BACK AT W	ORK?	
	☐ YES [	□ NO			☐ YES	□ №	IF YES, D	ATE RETURNE	D TO WORK?
RETURN TO WORK STATUS			DATE I	EMPLOYEE	LAST WC	ORKED V	WAS INJUR	Y FATAL? IF YES	S, DATE OF DEATH
☐ LIGHT ☐ MODIFIED ☐ REGU	LAR					E	YES	□ NO	
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIF	TING, CHEMICAL)	ŀ							
FOUNDATION MATERIAL OF CUROTANICE	WOLVED								
EQUIPMENT, MATERIAL OR SUBSTANCE IS	NAOFAED								
DO YOU QUESTION THE VALIDITY OF THE	CLAIM?	***************************************		<del>.</del>			<del>.</del>		
YES NO	mm;								
WITNESS INFORMATION/OTHERS INVOLVE	ED .					<u>.</u>			
NAME (FIRST, MI, LAST)		ADDRESS						PHONE NUMBE	ER
							-		
					******				

		47(0)								
PART OF BODY IN I	INJURY INFORM URED (E.G., HEAD, NECK, ARM, LEG)	ATION								
TART OF BODY WO										
NATURE OF INJURY	(E.G., FRACTURE, SPRAIN, LACERATION									
PRIOR INJURY OR I	PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)									
YES I	NO									
TREATMENT ("X" AI										
☐ FIRST AID —	TREATMENT AND DATE OF 1 St TREATMENT	REATMENT AND DATE OF 1 <sup>St</sup> TREATMENT								
HOSPITAL/ CLINIC	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DA	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 <sup>St</sup> TREATMENT, LENGTH OF STAY AMBULANCE USED?								
	WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM?	WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATENT?  ☐ YES ☐ NO								
PHYSICIAN —										
	CUSTOMER SPECIFIC I	NEODWATION								
	COSTOMER SPECIFIC I	NFORMATION								
	ADDITIONAL COMMENTS	& INFORMATION								

### WORKERS' COMPENSATION – FIRST REPORT OF INJURY – STATE SPECIFIC QUESTIONS

### Alahama

Employee's County:

Return to work (Y/N):

At what Occupation:

At what Wage \$:

Return to work wage is per (Day, Week or Month):

Employer's ID (U.C. Account) Number:

What Specific Product(s) does the business produce:

Alaska - No Additional State Questions

### Arizona

Last Day of Work after injury:

Number of Days per Week Company usually Works:

Department Number:

If Validity of Claim is Doubted, state Reason:

Has injured been employed for more than 12 months (Y/N):

Was employee on overtime when injured (Y/N):

Arkansas - No Additional State Questions

### California

State Unemployment Insurance Account Number:

Date employee was provided Employee Claim Form:

Has your employee pre-designated a primary treating physician (Y/N):

Street Address:

If Yes, Primary Treating Physician-s

First Name: Last Name:

State: Zip:

City: Phone: If No, did your employee require medical treatment (Y/N):

If Yes, Treating Physicians

Last Name: Phone'

If No, and employee requires medical treatment in the future, you can go to our website WWW,MYWCOMPINFO.COM to find a provider in the Medical Provider Network.

Employer Federal ID Number

Does Employer have a salary continuation program (Y/N)

If "Yes" is this program registered with the state (Y/N)

Connecticut - No Additional State Questions

### Delaware

Employer's UC Reporting Number:

Employees County:

Returned to work (Y/N): If Yes, at same wage (Y/N):

### **District of Columbia**

Employer ID Number:

Returned to work (Y/N):

If Yes, at what Time:

AM/PM

At what Wage \$:

Per (Day, Week or Month):

Was injured hired in DC (Y/N):

Was employee in his/her regular occupation when injured (Y/N):

Was injured given Form #7 DCWC (Y/N):

Piece or Time Worker (piece, time or blank):

Florida - No Additional State Questions

### Georgia

Wage Rate at time of injury \$:

First Date employee failed to work a full day:

Did employee work the next day (Y/N):

Return to work Wage \$:

Return to work wage is per (Day, Week or Month):

### Hawaii

Was employee furnished meals or lodging (Y/N):

Idaho - No Additional State Questions

### Illinois

Has the injured worker signed a medical authorization (Y/N):

If yes, inform them to please fax the signed medical authorization to the med auth customer service specialist at 1-877-786-5567.

Indiana - No Additional State Questions

Iowa - No Additional State Questions

SIC Code:

Was worker admitted to hospital (Y/N):

If Yes, Date of Admission:

Was worker treated in emergency room only (Y/N):

Returned to work (Y/N):

If employee has returned to work, was return to light duty (Y/N):

Is further medical aid needed (Y/N):

Is compensation now being paid (Y/N):

If Yes, Date of first Initial Payment:

Fatal (Y/N):

If Yes, Name and Address of Dependents:

Kentucky - No Additional State Questions

### Louisiana

Employer's Federal ID Number:

Employer's Unemployment Insurance Reporting Number:

Returned to work (Y/N):

If Yes, at same wage (Y/N):

Last Full Day Paid:

If occupational disease, Date of Initial Diagnosis:

Parish (county) where injury occurred:

Employer's State Unemployment Insurance Account Number (UIAN): Federal Employer Insurance Number (FEIN):

Maryland - No Additional State Questions

### Massachusetts

Federal ID Number:

Returned to work (Y/N):

Did employee return to his/her regular occupation (Y/N):

Describe nature of business or article manufactured (S=Service,

W=Wholesale, R=Retail, M=Manufacturing);

Date Reported as work related:

### Michigan

Federal ID Number:

### Minnesota

Date employer notified of lost time:

NAICS Code Number:

Mississippi - No Additional State Questions

Missouri - No Additional State Questions

Montana - No Additional State Questions

Nebraska - No Additional State Questions

How long employed by you in Nevada

Years:

Months:

If Validity of Claim is Doubted, state Reason:

### **New Hampshire**

Federal I.D. Number:

Was the employee injured in his/her regular occupation (Y/N):

Was injured hired in New Hampshire (Y/N):

Number of Full-Time Employees:

Number of Part-Time Employees:

If leased or temporary worker, provide the Client's Business Name: Was accident caused by injured's failure to use safeguards or follow

regulations (Y/N): Probable Length of Disability:

Returned to work (Y/N):

At what Occupation:

Returned at Full Duty:

Returned at Alternative/Light Duty:

Initial treatment ("X" all that apply)

No medical treatment: Care provided by employer only (onsite): Emergency Care: Hospitalized: Outpatient:

Clinic:

Office Visit: Other-explain:

Is there a managed care program (Y/N):

# WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS

If Yes, Name of Provider:

Is there a written safety program in force (Y/N):

Is there an active safety committee (Y/N):

Employee-s Legal First Name (please validate):

New Jersey - No Additional State Questions

New Mexico - No Additional State Questions

### New York

Did you provide medical care (Y/N):

If Yes, When:

Returned to work (Y/N):

If Yes, at what Weekly Wage \$:

Injured workers Work Week (indicate days regularly worked):

Fatal (Y/N):

If Yes, Name and Address of nearest relative:

Relationship:

### North Carolina

Regular Wages per Day \$:

Average Weekly Wages with Overtime \$:

Returned to work (Y/N):

If Yes, at what Time:

AM/PM

If Yes, what Date:

Return to work at what Wage \$:

Per (Day, Week or Month):

Return to work at what Occupation:

### North Dakota - No Additional State Questions

### Ohio

Time Accident Reported to employer:

Has employee ever filed a previous application for this injury (Y/N): Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):

If Yes, specify Claim Number and Body Parts:

Employee's County:

Current Employer's Risk Number:

### Oklahoma

Was employment agreement made in Oklahoma (Y/N):

SIC Number:

Type of Ownership (P=Private, S=State Government,

C=County Government, L=Local Government):

### Oregon

Hospitalized overnight as inpatient (if emergency room only, answer N) (Y/N):

Was accident caused by failure of machinery or product (Y/N):

Did someone (not worker) cause accident (Y/N):

Time worker left work: AM/PM:

### Pennsylvania

Employee's County:

Bureau Code:

NAICS Code:

Employer s County:

Are you aware of a 'Panel of Physicians' for your Employer? (Y/N)

### Rhode Island

Federal ID Number:

First Full Day Lost from work:

Unemployment Insurance Number:

State of Hire:

Was this injury previously an "Incident Only" with no medical treatment and no lost time (Y/N):

If Yes, Date Employer first Notified of medical treatment or lost time:

Category of Injury or Illness ("X" all that apply):

Injury: Illness: Occupational Disease: Repetitive Trauma:

Occupational Hearing Loss:

### South Carolina - No Additional State Questions

### South Dakota

Federal ID Number:

Number of employees:

Body Part Injured Code (2 digits):

Cause of Injury Code (2 digits):

Nature of Injury Code (2 digits):

Was employee hired for temporary employment (Y/N):

Carrier Code:

Tennessee - No Additional State Questions

Texas - No Additional State Questions

Utah - No Additional State Questions

### Vermont

Federal ID Number:

Was employee hired in Vermont (Y/N):

Does the employer regularly employ 10 or more employees (Y/N):

Returned to work (Y/N): If Yes, at what Weekly Wage \$:

Was injured paid in full for the date disability began (Y/N):

Was employee injured at his/her regular occupation (Y/N): Fatal (Y/N):

If Yes, Name, Address and Relationship of Nearest Relative: Last Date Paid in Full:

### Virginia

Returned to work (Y/N):

If Yes, at what Wage \$:

Federal Tax ID Number:

Washington - No Additional State Questions

### West Virginia

Has the employee been given "The Employees and Physicians Report of Injury Form" (Y/N)

Wisconsin - No Additional State Questions

Wyoming - No Additional State Questions

U.S. Longshoreman (USDOL) - No Additional State Questions



# PRIVACY NOTICE

THE TRAVELERS INSURANCE COMPANIES

### PRIVACY POLICY

Thank you for selecting THE TRAVELERS INSURANCE COMPANIES as your workers compensation insurer. At THE TRAVELERS INSURANCE COMPANIES a subsidiary of Travelers, we recognize that privacy is important to you. That is why we are committed to protecting your privacy through the adoption of the following privacy principles:

### **Collection Of Information**

We collect, retain, and use information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, only where we believe that it will help or is necessary to provide you products and services or otherwise conduct our business. We collect nonpublic personal financial information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, from the following sources:

- information we receive from you or through your agent or broker on applications or other forms;
- information we receive from or about you in the process of adjusting claims;
- information about your other transactions, including risk control and other consulting services, with us, our affiliates or other third parties;
- information about your coverages and loss activity with other carriers; and
- information we receive from a consumer reporting agency.

Such information includes identifying information such as policyholder, participant, beneficiary or claimant name, address, and social security number; financial information such as income, payment history, or credit history; and, under certain circumstances, health information such as information about an illness, disability, or injury. It could also include information on claims with other insurance companies and us and the condition and maintenance of your property.

### **Disclosure Of Information**

We usually do not disclose nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, without your consent. However, in some circumstances we may disclose information to others without your prior authorization. The most common disclosures are to the following persons:

- our affiliated property and casualty insurance companies:
- state insurance departments, for their regulation of our business;
- other government authorities;
- our agents and brokers as necessary to conduct our business;
- organizations that perform underwriting and claims investigations;
- another insurance company to which you have applied for a policy or submitted a claim;
- · insurance support agencies, law enforcement agencies and our reinsurers; and
- any other third party, as permitted or required by law.

Most importantly, THE TRAVELERS INSURANCE COMPANIES does not and will not disclose or sell nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to anyone for marketing purposes.



### **Confidentiality And Security**

We restrict access to nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to those who need it to serve your insurance needs and to maintain and improve customer service. We maintain physical, electronic, and procedural safeguards that comply with federal and state laws and regulations to guard your nonpublic personal information.

### Disclosure and Protection of Former Customers' Information

We may disclose all the personal information we have collected, as described above. However, even if you no longer have a customer relationship with us, we will continue to follow our privacy policies and practices to protect your information.

### **Changes In Privacy Policy**

We may choose to modify our policy regarding the treatment of personal information at any time. Before we do so, we will notify you and provide an updated privacy notice.

WUNNAB09 Page 2 of 2



# IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION

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

For information about how Travelers compensates independent agents and brokers, please visit www.travelers.com, call our toll-free telephone number 1-866-904-8348, or request a written copy from Marketing at One Tower Square, 2GSA, Hartford, CT 06183.



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### **IMPORTANT**

# **Policy Audit Information**

### Dear Policyholder:

This policy is issued with an estimated premium based upon information provided through your Producer. This premium is subject to adjustment at the end of the policy period. At that time, you may receive a request for information in the mail or a premium auditor may contact you to review the necessary records. The information developed is needed to determine the final earned premium for this policy.

### **Record Maintenance**

In order to facilitate audit service, it is necessary to maintain proper records and have them available at the proper time. Based on the nature of your business, some of the following data will be necessary to complete the audit:

- 1. General Ledger, Financial Statements
- 2. Payroll Records, Time Books, State Unemployment Returns, FICA Returns, Individual Earnings Records-Monthly totals separated by type of work and overtime.
- 3. Cash Receipts, Sales Journal
- 4. Cash Disbursements Journal Including subcontractors, casual labor and material costs.
- 5. Certificates of Insurance

### **IMPORTANT COVERAGE NOTE:**

If you utilize subcontractors whose legal status is that of sole proprietor/partner, we may charge premium for these persons as provided under Part 5 of the policy contract even though certificates of insurance may exist. Please contact your producer if you have any questions regarding your Workers' Compensation coverage needs.

### Work in Other States

Please advise your Producer if employees are hired for work in states other than those listed in Item 3. of your policy. This will enable your producer to consider your need for coverage in accordance with state laws.

We appreciate the opportunity to serve you. If you have any questions about the enclosed policy or any insurance matters please contact your producer or your Company representative.

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# **ALASKA**

### NOTICE TO INSURED

Dear Policyholder:

This is to notify you that your Workers' Compensation and Employers Liability policy does not provide Other States Coverage for the State of Alaska.

If you have operations or start up an operation in Alaska, and it is not listed in Item 3A of the Information Page, you or your agent must notify us and request that this state be covered under your policy.

With receipt of your request for coverage, we will extend the policy to include this state.

Your Agent can provide you with necessary information and will assist you in obtaining coverage for this state.





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### **ARIZONA**

### **WORK EXPOSURE TO BODILY FLUIDS**

(HIV & AIDS)

### Dear Policyholder:

The Arizona Industrial Commission requires Employers to post Immediately Adjacent to the "Notice To Employers" an English language notice entitled "Work Exposure To Fluids". For those Employers who have a Spanish speaking work force the "Work Exposure To Fluids" is also printed in Spanish.

In addition, the Employer must also supply their Employees the Reporting Forms (Sample Attached) needed to report such exposures to bodily fluids. The Employer may secure a supply of these Reporting Forms from the Industrial Commission of Arizona.

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# **ATTENTION**

The following Posting Notices must be displayed in a prominent location in the workplace.

Please distribute these notices to the appropriate workplace locations.

In the event that additional copies are desired, please contact your agent and request the number of copies of the particular notices that you may need.

Posting notices for the states of MO, MN, NM and TX (Spanish Version) are provided in two separate forms which need to be connected to create one large notice to be posted.

Please contact us at <u>wcppn@travelers.com</u> for assistance in completing the healthcare provider information on posting notices in PA, GA, TN, and VA.

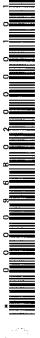
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# REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS

(THIS IS NOT A CLAIM FORM)

	Name					
	Last	First	M.I.	Birth Date		
1.				_ Phone No		
2.	Address			_ City	State	_ Zip
3.	Employer's or Firm's Full Name _					
4.	Employer's or Firm's Address					
5.	Date of Exposure		Time of Exposure _		A.M	P.M
6.	Address or Location of Exposure					
7.	Job Title					
8.	State fully how exposure occurred	d (be specific)				
			SAMPLE FOR	M		
	Employers should ob Commission of Arizona		•			
9.	List all persons present at the exp	oosure whom you	can identify.			
10.	What bodily fluid were you expos  Blood Vaginal flu  Semen Surgical flu	id		containing blood (D	,	
	Who did the bodily fluid come fro (Explain)  Are you aware of a break/rupture describe.					
13. 14.	Did exposure to bodily fluid take What specific part(s) of your body				<del></del>	
15.	NOTE: THIS REPORT MUST E YOUR WORK EXPOSUR OTHER REQUIRED STEPS:			IO LATER THAN	TEN (10) CALEND	AR DAYS OF
	A. YOU MUST HAVE BLOOD DR	AWN NO LATER	THAN TEN (10) CALEN	IDAR DAYS AFTER	EXPOSURE.	
	B. YOU MUST HAVE BLOOD TO				NO LATER THAN T	HIRTY (30)
	CALENDAR DAYS AFTER EXI C. YOU MUST BE TESTED O EXPOSURE, OR TESTED ANI AFTER THE EXPOSURE.	R DIAGNOSED	AS HIV POSITIVE NO	LATER THAN E	GHTEEN (18) MOI ATITIS C WITHIN SI	NTHS AFTER THE EVEN (7) MONTHS
	D. YOU MUST FILE A WORKER. ONE YEAR FROM THE DATE WORKERS' COMPENSATION	OF DIAGNOSIS	ON CLAIM WITH THE I OR POSITIVE BLOOD	NDUSTRIAL COMM TEST IF YOU WISH	IISSION OF ARIZON I TO RECEIVE BEN	IA NO LATER THAN EFITS UNDER THI
I H.	AVE FILED THIS FORM WITH MY	EMPLOYER AND	HAVE RECEIVED A	COPY OF THIS CO	MPLETE FORM.	
ΕM	IPLOYEE SIGNATURE:			:	DATE	
-14			BY THE INDUSTRIAL			
		- ·	FOR CARRIER USE			

EMPLOYER: KEEP WHITE ORIGINAL (NOTIFY CARRIER) EMPLOYEE: KEEP COPY



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