



THE HARTFORD
BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251

July 29, 2019

LOCKTON COMPANIES LLC / 41716006
5500 WAYZATA BLVD STE 510
MINNEAPOLIS MN 55416

Policy Information:

Policy Holder Details:	DIANA DAVIS SPENCER FOUNDATION 3 BETHESDA METRO CTR STE 118 BETHESDA MD 20814
Policy Number:	41 WEC AD7CDH

Enclosed please find information pertaining to your policy. Please contact us if you have any questions or concerns.

Thank you for selecting The Hartford for your business insurance needs.

Sincerely,

Your Hartford Service Team

Insurance Policy Billing Information

Thank you for selecting The Hartford for your business insurance needs.

Shortly, you will receive your first bill from us. You are receiving this Notice so you know what to expect as a valued customer of The Hartford. Should you have any questions after reviewing this information, please contact us at 866-467-8730, and we will be happy to assist you.

- o Your total policy premium will appear on your policy's Declarations Page. You will be billed based on the payment plan you selected.
- o You may pay the "minimum due" as it appears on your insurance bill or pay the policy balance in full.
- o An installment service fee is added to each installment. A late fee will also be applied if the "minimum due" is not **received** by the due date shown on your bill. Service and late payment fees do not apply in all states.
- o If you selected installment billing, any credit or additional premium due as the result of a change made to your policy, will be spread over the remaining billing installments. Additional premium due as a result of an **audit** will be billed in full on your next bill date following the completion of the audit.
- o If you elected Electronic Funds Transfer (EFT), policy changes may result in changes to the amount automatically withdrawn from your bank account. The invoice you receive following a policy change will include future withdrawal amounts. If you need to adjust or stop your next scheduled EFT withdrawal, please contact us **at least 3 days prior** to the scheduled withdrawal date at the telephone number shown below.
- o If you selected installment billing and pay the premiums for your first policy term on time, at renewal, your account may qualify for our "Equal Installment" feature. This means that the percentage due for each installment, including the initial renewal installment, will be the same throughout the policy term – helping you better manage cash flow. Equal installments will continue as long as you pay your premiums on time and no cancellation notices are issued for any policy on your account. If you no longer qualify for Equal Installments, future renewals will be billed based on the payment plan you selected, which includes a higher initial installment amount.
- o If your policy is eligible for renewal, your bill for the upcoming policy term will be sent to you approximately 30 days prior to your policy's renewal date. If your insurance needs change, please contact us at least 60 days prior to your renewal date so we can properly address any adjustments needed.
- o **One bill convenience** -- you have the option of combining all eligible Hartford policies on one single bill allowing you to make one payment for all policies on your account as payments are due.

You're In Control

In addition to selecting a bill plan option that best meets your budget, you have the flexibility to decide **how** your payments are made ...

- o **Repetitive EFT:** Sign up for Repetitive EFT payments and have payments automatically withdrawn from your bank account. This option saves you money by reducing the amount of the installment service fee.
- o **Pay Online:** Register at www.thehartford.com/servicecenter. Online Bill Pay is Quick, Easy and Secure!
- o **Pay by Check:** Send a check with your remittance stub in the envelope provided with your bill.
- o **Pay by Phone:** Call toll-free 1-866-467-8730.

Should you have any questions about your bill, please call Customer Service toll-free number:
1-866-467-8730 - 7AM – 7PM CST. We look forward to being of service to you.



Policy Number 41 WEC AD7CDH

Policy Effective Date 08/01/19

DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

Dear Hartford Insured,

Re: An Important Message to Workers Compensation Policyholders

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense.

An effective risk engineering program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations.

As a service to you, our valued customer, the Risk Engineering Department of The Hartford in cooperation with your independent agent, can assist you in establishing risk engineering strategies. If you would like assistance, please complete and return to us the reply portion of this brochure, or contact your independent agent.

Services Available

The following is a description of some of the services that we provide. The types of services that may be appropriate for your business depend upon the nature and size of your operations and the specific risk engineering services you have requested. The cost of risk engineering services may or may not be a part of your insurance premium. This depends on the extent of the requested services, agreements stated in your insurance policy and program, and statutory regulations that may require us to provide risk engineering services.

- 1) **Reference Materials** – Information about risk engineering topics that can be provided or made available to you to help you to enhance your risk engineering program.
- 2) **Telephone Consultation** – We can hold a teleconference with you to help you to evaluate your risk engineering program, identify areas for improvement, and recommend ways to implement such improvements.
- 3) **Onsite Consultation** – This consists of visiting your premises and helping you to assess and remedy your risk engineering needs onsite. This level of service is usually only appropriate for larger, higher hazard operations. The following are examples of some of the services that could be provided onsite:
 - o A review of your safety program to determine its adequacy and recommend modifications to that plan where needed.

- o Specific hazard evaluations, including ergonomics, industrial hygiene or material handling.
- o An initial survey and evaluation to address potential safety and health hazards.
- o Consultation to help management establish a comprehensive loss prevention Program.
- o Periodic summaries of accidents and analysis of causes.
- o Follow-up visits to check on progress and to provide continuing assistance when required.

A Word About OSHA

The Occupational Safety and Health Act of 1970 and similarly approved State Plans require employers to provide their employees with safe and healthful places to work. The Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor and similar State agencies enforce the regulations and apply penalties (civil and criminal) for non-compliance.

New standards have been developed, and through application and interpretation, standards change. You should make yourself aware of the standards that are applicable to your operations, and assure yourself that reasonable efforts are made to be in compliance. Copies of the standards are available through most libraries, or can be obtained through OSHA or the U.S. Government Printing Office.

You should know that neither The Hartford, nor any other party, can fulfill your obligations under the Law. Questions related to your legal obligations should be referred to your legal counsel.

Some Safety Reminders from The Hartford:

Have you considered:

- o The need to formalize your safety efforts to assure compliance and document your efforts?
- o The need to acquire Material Safety Data Sheets on all hazardous materials and the need for training on appropriate safety measures for your employees?
- o Requirements for record keeping of injuries, illnesses, and exposure to hazardous substances?
- o Assessing each job task to determine hazards and needed controls?
- o Measuring each exposure to hazardous substances to determine the need for control or personal protective equipment?
- o What mechanisms are in place to periodically verify that exposure controls (guards, ventilation systems, etc.) are still in place and working?
- o What specific training your employees and your supervisors need to avoid hazards in the workplace?
- o What specific OSHA standards apply to your business?

- o What mechanism exists to promptly investigate all accidents and 'near-misses' to limit the chance of another occurrence?
- o The financial impact an injury or illness has on your business?
- o What resources are available to you to help prevent accidents and illnesses?

Thank you for your business.

Sincerely,

The Hartford's Risk Engineering Department

THIS BROCHURE IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR A COMPLETE ON-SITE SAFETY INSPECTION CONDUCTED BY A QUALIFIED RISK ENGINEERING SPECIALIST. READERS ARE ENCOURAGED TO HAVE SUCH AN INSPECTION CONDUCTED BOTH TO PROMOTE WORKPLACE SAFETY AND TO COMPLY WITH APPLICABLE LAW.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, EITHER TELEPHONE OR MAIL THIS FORM TO YOUR HARTFORD AGENT OR NEAREST OFFICE OF THE HARTFORD

NOTICE TO ARKANSAS POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain accident prevention services at no additional cost as required by ARK. Code Ann. §11-9-409(D) and Rule 32. If you would like more information, call The Hartford's Risk Engineering Department, One Hartford Plaza, T-7, Hartford, CT 06155 at 1-866-586-0467. If you have any questions about this requirement, call the Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

NOTICE TO CALIFORNIA POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain occupational safety and health risk engineering consultation services as required by the California Labor Code, §6354.5, at no additional charge. If you would like more information call The Hartford's Risk Engineering Department at 1-866-586-0467 for occupational safety and health risk engineering consultation services.

California Workers Compensation insurance policyholders may register comments about the insurer's risk engineering consultation service by writing to:

State of California
Department of Industrial Relations
Division of Occupational Safety and Health
P.O. Box 420603
San Francisco, California 94142

NOTICE TO PENNSYLVANIA POLICYHOLDERS

The Hartford maintains and provides accident and illness prevention services as required by the nature of the policyholder's business or its operation, in accordance with the Pennsylvania Workers' Compensation Act. For more information about these services contact your Hartford Agent or nearest office of The Hartford.

NOTICE TO TEXAS POLICYHOLDERS

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

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

If you would like more information, contact The Hartford at 1-866-586-0467 and email contactriskengineering@thehartford.com for accident prevention services or 1-877-952-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at <http://www.tdi.texas.gov> or by mail to Texas Department of Insurance, Division of Workers' Compensation, MS-8, at 7551 Metro Center Drive, Austin, Texas 78744-1645.

To The Hartford's Risk Engineering Department:

Yes – I am interested in obtaining information concerning:

General Topics	Business Continuity	Construction
<input type="checkbox"/> Accident Analysis	<input type="checkbox"/> Business Travel Safety	<input type="checkbox"/> Construction Site Consultation
<input type="checkbox"/> Accident Investigations	<input type="checkbox"/> Contingency Planning Overview	<input type="checkbox"/> Construction Equipment Hazards
<input type="checkbox"/> Establishing a Risk Engineering Program	<input type="checkbox"/> Emergency/Disaster Response	<input type="checkbox"/> Hazard Communication
<input type="checkbox"/> Hazard Recognition	<input type="checkbox"/> Emergency Evacuation Drills	<input type="checkbox"/> Ladders & Scaffolds
<input type="checkbox"/> Safety Committees	<input type="checkbox"/> Emergency Preparedness Planning	<input type="checkbox"/> Trenching & Evacuation
		<input type="checkbox"/> Fall Protection
Ergonomics	Industrial Hygiene	Property
<input type="checkbox"/> Back Injury Prevention	<input type="checkbox"/> Hazard Communication	<input type="checkbox"/> Automatic Sprinkler System
<input type="checkbox"/> Computer Workstation	<input type="checkbox"/> Industrial Hygiene (general)	<input type="checkbox"/> Flammable Liquids
<input type="checkbox"/> Cumulative Trauma Disorders	<input type="checkbox"/> Indoor Air Quality	<input type="checkbox"/> Fire Prevention and Protection
<input type="checkbox"/> Ergo Train-the-Trainer	<input type="checkbox"/> Noise Exposures	<input type="checkbox"/> Fire Drill and Evacuation
<input type="checkbox"/> Telecommuting	<input type="checkbox"/> Respiratory Protection	<input type="checkbox"/> Hot Work Permit Program
Transportation	Workers' Compensation	Other Topics
<input type="checkbox"/> 3-D Driver Training	<input type="checkbox"/> Bloodborne Pathogens	<input type="checkbox"/> Business Risk Management
<input type="checkbox"/> Driving Defensively	<input type="checkbox"/> Drug Screening	<input type="checkbox"/> General Liability Investigations
<input type="checkbox"/> Fleet Newsletter	<input type="checkbox"/> Machine Safeguarding	<input type="checkbox"/> Product Liability Programs
<input type="checkbox"/> Guide to Successful Driver Mgmt	<input type="checkbox"/> Return to Work Programs	<input type="checkbox"/> Safety Training
<input type="checkbox"/> School Bus Driving Tips	<input type="checkbox"/> Slip and Falls	<input type="checkbox"/> Security/Terrorism

Name _____

Company _____ **Policy #** _____

Address _____

City & State _____ **Zip Code** _____

Email Address: _____ **Telephone** _____

For more information on the above, you can visit our website at

<https://www.thehartford.com/riskengineering>

Or you may forward your request to:

Fax line: 1-860-723-4459

Or mail to:

**The Hartford Financial Services Group
Risk Engineering Department
One Hartford Plaza, T-7
Hartford, CT 06155**



MAINTAINING YOUR RECORDS FOR AUDIT PURPOSES

WHAT IS A PREMIUM ADJUSTMENT?

When your Workers' Compensation policy was issued you paid a deposit premium based on the nature of your business and estimates of your payroll. At the end of the policy period, we conduct an audit to compare the estimates against the actual figures and operations. Based on this comparison an adjustment is made. If the actual premium is less than what you already have paid, a refund will be made. If it's more, you will be billed for the difference. These adjustments are subject to any minimum premiums that apply.

HOW WILL THE PREMIUM ADJUSTMENT BE MADE?

On smaller, less complex operations we may e-mail you, call you, or mail you a request to ask you to provide the information via our online web-based portal, mail or telephone. If we require this information, we will provide an electronic link to, or a paper copy of, the necessary forms for you to complete.

On larger, more complex operations one of our Premium Auditors will contact you for an appointment. You will be contacted either by e-mail, telephone or mail. If directed, the auditor will contact your accountant to obtain as much information as possible and contact you at a later time for additional information that may be needed.

BASIS OF PREMIUM

Remuneration (Payroll) in most states, includes:

Payment of: Wages, bonuses, commissions, overtime,* sick pay, vacation pay,* tool allowances, contributions to individual retirement accounts, employee contributions to employee benefit plans.

Payments on basis of: Piece work, incentive plans, profit sharing.
The value of: Housing furnished to employees,* meals furnished to employees,* store certificates, merchandise and other dollar substitutes.

Remuneration does not include:

- Employer contributions to a group insurance or pension plan other than statutory plans of insurance.
- Special awards for individual inventions or discoveries.
- Overtime.*

Subcontractors. In the absence of other insurance, most state laws hold a contractor responsible for injuries to employees of subcontractors. At the time of audit Certificates of Insurance must be available for subcontractors with employees, in order to avoid payment of premium.

Independent Contractors, without employees, whose duties closely resemble those of an employee, will be considered your employee with the appropriate premium charged.

The actual working relationship between you and the Independent Contractor is examined. Items such as, but not limited to: whether the work performed is an integral part of your operations, whether you have the right to control the details of the work, the method of payment, who supplied the materials used, does the person regularly work for others, whose regulatory authority did person operate under, whether the person is involved in a separate and distinct business offering the same services to the public.

RECORDS

As part of the policy conditions, we are allowed to examine your financial books and records to determine actual exposures and operations. We would appreciate your cooperation in making the needed records available for the auditor's inspection.

What Records Will Be Needed?

The records needed will vary. In most cases, the Premium Auditor will be able to obtain the necessary audit data from two or more of the following records: Journals, Ledgers, State and Federal Tax Reports, Individual Earning Cards, Checkbooks and Contracts.

How You Should Keep Your Records

By maintaining your payroll records in accordance with the following guidelines, you might reduce your insurance costs.

Overtime. In most states, the amount paid in excess of straight time pay can be deducted if it can be verified in your records. You must maintain your records to show pay separately by employee and in summary by classification of work.

***Division of an employee's payroll** to more than one classification is not allowed in most states.

Exception: For construction, erection or stevedoring operations the payroll of an employee may be allocated to each type of work performed if proper records are kept. Your records must show the number of hours and amount of payroll for each type of work. If you do not keep such a breakdown, the full salary must be charged to the highest rated classification to which the employee is exposed.

Executive Officers in most states are considered employees of their corporation and included in the

computation of premium. Their remuneration is assigned without division to the actual operation in which they are engaged. If their duties are the same as those of a worker, foreman or superintendent, their payroll is assigned to the classification that develops the highest payroll. Minimum and maximum payrolls apply to executive officers.

Automated Records. If your records are automated or you plan to automate in the near future you can obtain maximum benefits by setting up your records to include insurance requirements. Our Premium Auditor will be pleased to assist you in setting up your records. Contact your Hartford Representative if you would like this assistance.

NOTE: The contents of this publication are not intended to supersede any definitions or conditions of your policy, the Workers' Compensation Law or any legal rulings.

**Your state may have specific rules or exceptions. Please contact your Hartford Representative for details that may apply and answer questions you may have.*



IMPORTANT NOTICE TO POLICYHOLDERS

DISCLOSURE PURSUANT TO TERRORISM RISK INSURANCE ACT

A. Disclosure Of Premium

In accordance with the federal Terrorism Risk Insurance Act, as amended (TRIA), we are required to provide you with a notice disclosing the portion of your premium, if any, attributable to coverage for "certified acts of terrorism" under TRIA. The charge for terrorism is shown in Item 4 of the Information Page or on the Schedule. The rate for terrorism will apply as of the effective date of your policy. The terrorism rates are subject to change at any time based on state regulatory action.

B. The following definition is added with respect to the provisions of this endorsement:

1. A "certified act of terrorism" means an act that is certified by the Secretary of the Treasury, in accordance with the provisions of TRIA, to be an act of terrorism under TRIA. The criteria contained in TRIA for a "certified act of terrorism" include the following:
 - a. The act results in insured losses in excess of \$5 million in the aggregate, attributable to all types of insurance subject to TRIA; and
 - b. The act results in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of an United States mission; and
 - c. The act is a violent act or an act that is dangerous to human life, property or infrastructure and is 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.

C. Disclosure Of Federal Share Of Terrorism Losses Under TRIA

The United States Department of the Treasury will reimburse insurers for a portion of such insured losses as indicated in the table below that exceeds the applicable insurer deductible:

Calendar Year	Federal Share of Terrorism Losses
2015	85%
2016	84%
2017	83%
2018	82%
2019	81%
2020 or later	80%

However, if aggregate insured losses attributable to "certified acts of terrorism" under TRIA exceed \$100 billion in a calendar year, the Treasury shall not make any payment for any portion of the amount of such losses that exceeds \$100 billion. The United States Government has not charged any premium for their participation in covering terrorism losses.

D. Cap On Insurer Liability for Terrorism Losses Under TRIA

If aggregate insured losses attributable to "certified acts of terrorism" under TRIA exceed \$100 billion in a calendar year and we have met, or will meet, our insurer deductible under TRIA we shall not be liable for the payment of any portion of the amount of such losses that exceeds \$100 billion. In such case, your coverage for terrorism losses may be reduced on a pro-rata basis in accordance with procedures established by the Treasury, based on its estimates of aggregate industry losses

and our estimate that we will exceed our insurer deductible. In accordance with Treasury procedures, amounts paid for losses may be subject to further adjustments based on differences between actual losses and estimates.

- E. All other terms and conditions remain the same.**



POLICYHOLDER DISCLOSURE NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed. As defined in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury-in consultation with the Secretary of Homeland Security, and the Attorney General of the United States-to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a \$100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds \$100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed \$100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is \$ 0 _____, and does not include any charges for the portion of losses covered by the United States government under the Act.

Name of Insurer: Twin City Fire Insurance Company

Policy Number: 41 WEC AD7CDH



IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized \$2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

- () 1. I reject this deductible option and elect that the company pay all benefits due under my policy.
- () 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 41 WEC AD7CDH		
Employer Name DIANA DAVIS SPENCER FOUNDATION	Date	Signature and Title
Agent Name LOCKTON COMPANIES LLC	Date	Signature

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

☐ Job applicant

☐ Routine fitness for duty

☐ Reasonable suspicion

☐ Follow-up testing to
Employee Assistance Program

Notice of Employer's Drug Testing Policy:

☐ Copy to all employees prior to testing

☐ Show notice of drug testing on vacancy
announcements

☐ Posted on employer's premises

☐ Copies available in personnel office or
other suitable locations

☐ Copy to job applicants prior to testing

☐ General notice given 60 days prior to testing

☐ No notice required because the
employer had a drug testing program
in place prior to July 1, 1990

Education:

☐ Resource file on providers

☐ Employee Assistance Program

☐ Education

Name of Medical Review Officer: _____

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

B. Phone No.: () _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employer Name

Date

Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature

Date

Expiration of Commission

Maryland Alcohol- and Drug-Free Workplace Premium Credit Employer Certification Form

The Hartford* offers a 4% credit to Maryland employers that establish and maintain qualifying alcohol and drug free workplace programs. An employer may receive a credit by submitting a written statement certifying that the employer has established and maintains an alcohol and drug free workplace policy that includes one or more of the qualifying programs found in section 11-329(f)(3) of the Maryland statutes.

A 4% credit will be granted to Maryland employers that establish and maintain qualifying alcohol and drug free workplace programs in accordance with section 11-329(f)(3) of the Maryland statutes.

The qualifying programs found in section 11-329(f)(3) of the Maryland statutes are:

- o Alcohol and drug testing program
- o Employee education program on alcohol and drug abuse
- o Supervisor education program on alcohol and drug abuse
- o Employee assistance program that includes referrals of employees for appropriate diagnosis, treatment and assistance
- o Program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing
- o Any other program the insurer deems effective to encourage an alcohol and drug free Workplace

To qualify for a credit, the employer must provide a written copy or copies of the employer's above noted alcohol and drug testing program, employee education program, supervisor education program, employee assistance program, and/or post-accident alcohol and drug testing requirement.

To qualify for a credit, the employer must provide a copy of an agreement with an outside entity to conduct the alcohol and drug testing services regarding qualifying program shown in first bullet above.

The employer's program(s) must be in accordance with Maryland statutes and any rating plan rules established by the carrier and approved by the Maryland Insurance Administration.

An employer may request a premium credit by submitting a written statement to The Hartford certifying that the employer has established and maintains an alcohol- and drug-free workplace policy that includes one or more of the qualifying programs found in section 11-329(f)(3) of the Maryland statutes.

The Hartford will not provide a premium credit if the employer is required under federal or state law to test its employees for drugs or otherwise provide an alcohol- and drug-free workplace.

The Hartford will apply the premium credit to the employer's policy pro rata from the date that the employer's certification is received by the carrier.

The premium credit must be based on evidence contained in our file at the time that the credit is allowed. The Hartford may require additional information from the employer to verify that the employer has established and maintains a qualifying program.

An employer certification is required for each policy year that the employer receives a premium credit.

* The Hartford means Hartford Fire Insurance Company and its property & casualty affiliates.

Maryland Alcohol- and Drug-Free Workplace Premium Credit Employer Certification Form

To Apply for a Credit:

- 1.) Complete the Employer information listed below.

Employer Name:

Employer Address:

Employer City, State, Zip:

Policy Number and Effective Date:

- 2.) Circle the qualifying programs listed below that have been established and are maintained by your company. Written copies of the circled items must be provided with this certification form in order to qualify for a credit. A written copy of an agreement with an outside entity to conduct alcohol and drug testing is required to qualify for a credit if item "A" is selected below.

- A. Alcohol and drug testing program
- B. Employee education program on alcohol and drug abuse
- C. Supervisor education program on alcohol and drug abuse
- D. Employee assistance program that includes referrals of employees for appropriate diagnosis, treatment and assistance
- E. Program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing
- F. Any other program the insurer deems effective to encourage an alcohol and drug free Workplace

- 3.) Sign and date the certification form in the space provided below. Return the certification form to The Hartford along with written copies of items as required under item 2 above.

Completed by:

Print Name

Signature

Title:

Date:



INSTRUCTIONS

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

As of January 1, 1990, California employers are required by law to furnish a claim form to an injured worker within one working day of knowledge of a work-related injury or illness (other than First Aid). While it is mandatory for the employer to furnish the claim form to the employee, **it is not mandatory for the employee to complete it.**

The employer should complete sections 9-17, with the exception of section 13 (which reads, "Date employer received claim form"). This is to be completed **after** the claimant has completed his or her portion of the claim form and returned it to you, at which time section 13 should be **immediately** filled out or date stamped.

Penalties can be invoked if employers fail to provide an injured employee an EMPLOYEE'S CLAIM FOR COMPENSATION BENEFITS form or if employers fail to report the claim to the workers' compensation insurance carrier.

DO NOT DELAY REPORTING A CLAIM TO THE HARTFORD:

Whether or not the employee completes the EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS, please contact The Hartford's **LossConnect (1-800-327-3636)** to report every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond First Aid.

Workers' Compensation and Employers' Liability Business Insurance Policy



INFORMATION PAGE

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

INSURER: Twin City Fire Insurance Company
ONE HARTFORD PLAZA HARTFORD CT 06155



NCCI Company Number:
Company Code: 7

14974

POLICY NUMBER:
Previous Policy Number:

41 WEC AD7CDH
41 WEC AB7NOO

Suffix
LARS RENEWAL

1. **Named Insured and Mailing Address:** DIANA DAVIS SPENCER FOUNDATION
(No., Street, Town, State, Zip Code) 3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

FEIN Number: 13-6165382

State Identification Number(s): Refer to the EXTENSION OF THE INFORMATION PAGE – WC990365.

The Named Insured is: Corporation

Business of Named Insured: Grantmaking Foundations

Other workplaces not shown above: See Endorsement - WC990366

2. **Policy Period:** **From** 08/01/19 **To** 08/01/20 **ANNUAL**
12:01 a.m., Standard time at the insured's mailing address.

Producer's Name: LOCKTON COMPANIES LLC
5500 WAYZATA BLVD STE 510
MINNEAPOLIS MN 55416

Producer's Code: 41716006

Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
(877) 853-2582

Total Estimated Annual Premium: \$5,055

Deposit Premium:

Policy Minimum Premium: \$720 CA (Includes Increased Limit Min. Prem.)

Audit Period: ANNUAL

Installment Term: Ten Pay (25%Down+9@8.33%)

The policy is not binding unless countersigned by our authorized representative.

Countersigned by

Susan S. Castaneda
Authorized Representative

07/29/19

Date

3. A. Workers Compensation Insurance: Part one of the policy applies to the Workers Compensation Law of the states listed here: DC SEE ENDORSEMENT - WC 99 03 67

B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in Item 3.A.

The limits of our liability under Part Two are:

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

C. Other States Insurance: Part Three of the policy applies to the states, if any , listed here:

ALL STATES EXCEPT NORTH DAKOTA, OHIO, WASHINGTON, WYOMING, U.S.TERRITORIES AND STATES DESIGNATED IN ITEM 3.A. OF THE INFORMATION PAGE.

D. This policy includes these endorsements and schedule:

SEE ENDORSEMENT-WC 99 03 68

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
Total Standard Premium			\$3,871
Expense Constant			\$260
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement			\$608
Catastrophe (Other Than Certified Acts Of Terrorism)			\$288
Estimated Annual Premium (before Surcharges)			\$5,027
Total Estimated Surcharges			\$28

*See the attached Schedule(s) of Operations for Location and State Level Premium Information

Total Estimated Annual Premium:	\$5,055
Deposit Premium:	
Policy Minimum Premium:	\$720 CA (Includes Increased Limit Min. Prem.)

Interstate/Intrastate Identification Number: Refer to Schedule of Operations

Labor Contractors Policy Number:

NAICS: 813211

SIC: 6732



EXTENSION OF THE INFORMATION PAGE - ITEM 1 - OTHER WORKPLACES

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

Item 1 of the Information Page is completed to include other workplaces of the named insured:

3 BETHESDA METRO CTR STE 118, BETHESDA, MD 20814-6368
2029 CONNECTICUT AVE NW APT 2, WASHINGTON, DC 20008-6142
12665 VILLAGE LN APT 2519, PLAYA VISTA, CA 90094-2840
5769 FLORAL AVE, JACKSONVILLE, FL 32211-7022



EXTENSION OF THE INFORMATION PAGE - ITEM 3.A - STATES COVERED

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

Item 3.A. of the Information Page is completed to include the following states:

District of Columbia	DC
California	CA
Florida	FL
Maryland	MD



EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

Item 3.D. of the Information Page is completed to include the following endorsements:

WC000000C	WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
WC000001A.1	INFORMATION PAGE
WC000001A.2	INFORMATION PAGE
WC000313	WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT
WC000403	EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
WC000414A	90-DAY REPORTING REQUIREMENT- NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT
WC000419	PREMIUM DUE DATE ENDORSEMENT
WC000421D	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
WC000422B	TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT
WC000424	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC040301BB	POLICY AMENDATORY ENDORSEMENT - CALIFORNIA
WC040360B	EMPLOYERS LIABILITY COVERAGE AMENDATORY ENDORSEMENT - CALIFORNIA
WC040421	OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
WC040601A	CALIFORNIA CANCELLATION ENDORSEMENT
WC080601	DISTRICT OF COLUMBIA CANCELLATION ENDORSEMENT
WC090303	FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
WC090403B	FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT



EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

Item 3.D. of the Information Page is completed to include the following endorsements:

WC090407	FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT
WC090408A	FLORIDA INSUFFICIENT FUNDS ENDORSEMENT
WC090606	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT
WC090607A	FLORIDA INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT NOTIFICATION
WC190402A	MARYLAND ALCOHOL- AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT
WC190601G	MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT
WC190602	MARYLAND NOTIFICATION OF 45-DAY UNDERWRITING PERIOD ENDORSMENT
WC550011D	Employees Claim for Workers compensation Benefits
WC880400I	Notice to Employees - Injuries Caused By Work (TITLE IN SPANISH)
WC880401I	Notice to Employees - Injuries Caused By Work
WC990001I	Signature/ Copyright
WC990002	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY BUSINESS INSURANCE POLICY
WC990005	SCHEDULE OF OPERATIONS
WC990302B	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990358B	AMENDMENT TO WORKERS COMPENSATION BROAD FORM ENDORSEMENT - EMPLOYERS LIABILITY STOP GAP COVERAGE
WC990366	EXTENSION OF THE INFORMATION PAGE - ITEM 1 - OTHER WORKPLACES
WC990367	EXTENSION OF THE INFORMATION PAGE - ITEM 3.A - STATES COVERED



EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

Item 3.D. of the Information Page is completed to include the following endorsements:

WC990368

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D. - ENDORSEMENTS

WC990375

CALIFORNIA INSTALLMENT FEE DISCLOSURE ENDORSEMENT



SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 41 WEC AD7CDH

Schedule Number: 01-04-03

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

DIANA DAVIS SPENCER FOUNDATION

12665 VILLAGE LN APT 2519

PLAYA VISTA CA 90094

NAICS: 813211

SIC: 6732

NO. OF EMPL: 1

FEIN: 13-6165382

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES-N O C	125,000.00	0.710000	888

Total State Summary

Total Class Premium			888
CA Territorial Differential		1.088300	78
Small Policy Credit		3	-29
Total Estimated Annual Standard Premium			937
Terrorism Risk Insurance Program Reauthorization Act	125,000.00	0.020000	25
Disclosure Endorsement			
CA User Fund		1.447900	14
CA Fraud		0.287800	3
CA Uninsured Employers Benefit Trust Fund		0.083100	1
CA Subsequent Injuries Benefit Trust Fund Assessments		0.273700	3
CA Occupational Safety & Health Fund		0.376500	4
CA Labor Enforcement & Compliance Fund		0.343100	3
Total Estimated Annual Premium			990

Countersigned by _____

Authorized Representative



SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 41 WEC AD7CDH

Schedule Number: 01-08-02

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

DIANA DAVIS SPENCER FOUNDATION
2029 CONNECTICUT AVE NW APT 2
WASHINGTON DC 20008

FEIN: 13-6165382

NAICS: 813211

SIC: 6732

NO. OF EMPL: 1

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	IF ANY	0.120000	0

Total State Summary

Total Class Premium		0
Expense constant		260
Terrorism Risk Insurance Program Reauthorization Act	0.070000	0
Disclosure Endorsement		
Catastrophe (other than certified acts of terrorism)	0.020000	0
Total Estimated Annual Premium		260

Countersigned by _____ Authorized Representative



SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 41 WEC AD7CDH

Schedule Number: 01-09-04

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

DIANA DAVIS SPENCER FOUNDATION
5769 FLORAL AVE
JACKSONVILLE FL 32211

NAICS: 813211

SIC: 6732

NO. OF EMPL: 1

FEIN: 13-6165382

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	65,000.00	0.180000	117

Total State Summary

Total Class Premium			117
Emp liab increased limits		0.014000	2
Total Estimated Annual Standard Premium			119
Terrorism Risk Insurance Program Reauthorization Act	65,000.00	0.010000	7
Disclosure Endorsement			
Total Estimated Annual Premium			126

Countersigned by _____
Authorized Representative



SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 41 WEC AD7CDH

Schedule Number: 01-19-01

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

NAICS: 813211

SIC: 6732

NO. OF EMPL: 0

FEIN: 13-6165382

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

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per \$100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	1,439,700.00	0.170000	2,447

Total State Summary

Total Class Premium			2,447
Waiver of Subrogation			250
Emp liab increased limits		0.011000	27
Employer Liability Increase Limits balance to Minimum Premium			91
Total Estimated Annual Standard Premium			2,815
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	1,439,700.00	0.040000	576
Catastrophe (other than certified acts of terrorism)	1,439,700.00	0.020000	288
Total Estimated Annual Premium			3,679

Countersigned by _____ Authorized Representative

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

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INFORMATION PAGE		PART TWO - Continued	
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B. Who Is Insured.....	1	I. Actions Against Us.....	4
C. Workers Compensation Law.....	1	PART THREE - OTHER STATES INSURANCE	4
D. State.....	1	A. How This Insurance Applies.....	4
E. Locations.....	1	B. Notice.....	5
PART ONE - WORKERS COMPENSATION INSURANCE	1	PART FOUR - YOUR DUTIES IF INJURY OCCURS	5
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B. We Will Pay.....	1	A. Our Manuals.....	5
C. We Will Defend.....	1	B. Classifications.....	5
D. We Will Also Pay.....	1	C. Remuneration.....	5
E. Other Insurance.....	2	D. Premium Payments.....	5
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H. Statutory Provisions.....	2	G. Audit.....	6
PART TWO - EMPLOYERS LIABILITY INSURANCE	2	PART SIX - CONDITIONS	6
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IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.



WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. The Policy

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

B. Who Is Insured

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

C. Workers Compensation Law

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

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

D. State

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

E. Locations

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

PART ONE - WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

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

2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

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

F. Payments You Must Make

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

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

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

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury.

You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

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

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

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

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.

2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last

exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

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

B. We Will Pay

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

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

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

C. Exclusions

This insurance does not cover:

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

This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Noappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651-1654), the Federal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901-944) any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

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

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

E. We Will Also Pay

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

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

F. Other Insurance

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

G. Limits of Liability

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

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

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

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

I. Actions Against Us

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

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

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

PART THREE - OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were

listed in Item 3.A. of the Information Page.

3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.
4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the

Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

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

PART FOUR - YOUR DUTIES IF INJURY OCCURS

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

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

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

PART FIVE - PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis.

This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. All your officers and employees engaged in work covered by this policy; and

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

D. Premium Payments

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

E. Final Premium

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

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

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

F. Records

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

G. Audit

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

PART SIX - CONDITIONS

A. Inspection

We have the right, but are not obligated 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 that 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.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DUE DATE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

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.**

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

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

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

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
AL, AR, CO, CT, DC, DE, GA, IA, ID, IL, KY, MD, ME, MI, MN, MS, NE, NH, NJ, NM, OR, RI, SC, SD, TN, UT, VA, VT, WV	Estimated Annual Premium	Up to two times
AZ, HI, KS, OK, WI	Estimated Annual Premium	Two times
NC	Estimated Annual Premium	Up to three times
NV	Estimated Annual Premium	Up to one times



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICY AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

1. **Minors Illegally Employed - Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.
2. **Punitive or Exemplary Damages - Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.
3. **Increase in Indemnity Payment - Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy

and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars (\$100).

If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.

4. **Application of Policy.** Part One, "Workers Compensation Insurance", A, "How This Insurance Applies", is amended to read as follows:
This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in

Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.

6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.
7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.
8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work

covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

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

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

It is further agreed that this policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in this policy or such endorsements shall affect such contract or any rights, duties, or privileges arising therefrom.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

The insurance afforded by Part Two (Employers' Liability Insurance) by reason of designation of California in Item 3 of the Information Page is subject to the following provisions:

A. "How This Insurance Applies," is amended to read as follows:

A. How This Insurance Applies

This employers' liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury means a physical injury, including resulting death.

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

C. The **"Exclusions"** section is modified as follows (all other exclusions in the **"Exclusions"** section remain as is):

1. Exclusion 1 is amended to read as follows:
 1. liability assumed under a contract.
2. Exclusion 2 is deleted.
3. Exclusion 7 is amended to read as follows:
 7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.
4. The following exclusions are added:
 1. bodily injury to any member of the flying crew of any aircraft.
 2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.
 3. liability arising from California Labor Code Section 2810.3 which relates to labor contracting.

Countersigned by _____

Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

You must provide us, or our authorized representative, access to records necessary to perform a payroll verification audit. If you fail to provide access within 90 days after expiration of the policy, you are liable to pay a total premium equal to 3 times our current estimate of the annual premium for your policy. In addition, if you fail to provide access after our third request within a 90 day or longer period, you are also liable for our costs in attempting to perform the audit unless you provide a compelling business reason for your failure.

We will contact you to schedule appointments during normal business hours.

We will notify you of your failure to provide access by mailing a certified, return-receipt document stating the increased premium and the total amount of our costs incurred in our attempt(s) to perform an audit. In addition to any other obligations under this contract, 30 days after you receive the notification, you will be obligated to pay the total premium and costs referenced above. If, thereafter, you provide access to your records within three years after the policy expires, or within another mutually agreed upon time, and we succeed in performing the audit to our satisfaction, we will revise your total premium and the costs due to reflect the results of the audit.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA CANCELLATION ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

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

The cancellation condition in Part Six (Conditions) of the policy is replaced by these conditions:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy for one or more of the following reasons:
 - a. Non-payment of premium;
 - b. Failure to report payroll;
 - c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
 - d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
 - e. Material misrepresentation made by you or your agent;
 - f. Failure to cooperate with us in the investigation of a claim;
 - g. Failure to comply with Federal or State safety orders;
 - h. Failure to comply with written recommendations of our designated loss control representatives;

- i. The occurrence of a material change in the ownership of your business;
 - j. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
 - k. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
 - l. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Item (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of cancellation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
 4. The policy period will end on the day and hour stated in the cancellation notice.

Countersigned by: _____

Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**DISTRICT OF COLUMBIA
CANCELLATION ENDORSEMENT**

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail or deliver to you and the Mayor not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing this notice to you at your mailing address last known to us will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

C. Exclusion 5, Section C.of Part Two of the policy is replaced by the following:

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result

of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

This endorsement adds the following provisions to Part Five- Premium, G. Audit, of the policy:

We are required to complete the premium audit process no later than 90 days after policy termination. If you fail to return voluntary audit requests or refuse to cooperate in completing a final physical audit, you must pay a premium to us not to exceed three times the most recent estimated annual premium on this policy subject to the following conditions:

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.
2. We document the audit file regarding the above attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

If you do not provide all of the specific records required and if we satisfy the conditions above on or before 90 days from the date of policy termination, we may continue to try and conduct the audit and/or re-open the audit for up to three years from the date of policy termination. Alternatively, we may immediately bill you a premium not to exceed three times the most recent estimated annual premium on this policy. If you provide all of the specific records required to complete the premium audit process within the three year period, we will determine your final premium in accordance with Part Five-Premium, E. Final Premium of the policy.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA INSUFFICIENT FUNDS ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

G. Insufficient Funds

Our rules allow us to impose an insufficient funds fee of up to \$15 per occurrence if you make a payment of premium by debit card, credit card, electronic funds transfer (EFT), or electronic check that is returned, declined, or cannot be processed due to insufficient funds. However, we will not charge you an insufficient funds fee if the failure in payment resulted from fraud or misuse on your account from which the payment was made and such fraud or misuse was not attributed to you.

The Schedule below shows the insufficient funds fee we will impose if you make a payment of premium by debit card, credit card, electronic funds transfer (EFT), or electronic check that is returned, declined, or cannot be processed due to insufficient funds.

Schedule

Insufficient Funds Fee	<u>\$15</u>
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THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

We will safeguard the information and maintain its confidentiality. We will limit use of the information to verifying compliance with the terms of the policy.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY
ASSOCIATION SURCHARGE ENDORSEMENT**

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

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

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

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

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

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

F. Florida Workers' Compensation Insurance Guaranty Association Surcharge

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

Schedule

Surcharge rate 0 %



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

D. Cancellation and Nonrenewal

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel or nonrenew this policy as follows:
 - a. If the policy is cancelled for nonpayment of premium, we will file with the Maryland Workers Compensation Commission's designee, and serve you by certificate of mailing, not less than 10 days advance written notice stating when the cancellation will take effect.
 - b. If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service to you, not less than 45 days advance written notice stating when the cancellation or nonrenewal will take effect.

Mailing this notice by certified mail to you at your mailing address last known to us creates a presumption of actual delivery of notice. You may be able to rebut this presumption by providing evidence that the notice was not delivered.

3. The effective dates of the cancellation or nonrenewal are determined as follows:
 - a. Except for cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation or nonrenewal notice, or 45 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
 - b. For cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation notice, or 10 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
4. The provisions in D-2 and D-3 do not apply to the cancellation of a policy or binder during the 45-day underwriting period in accordance with Section 12-106 of Maryland Code, Insurance. Refer to Section 12-106 of Maryland Code, Insurance for the cancellation provisions that apply during the 45-day underwriting period.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MARYLAND NOTIFICATION OF 45-DAY UNDERWRITING PERIOD ENDORSMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

1. Your policy is subject to a 45-day underwriting period beginning on the effective date of coverage. In accordance with Md. Code Ann. Ins. §12-106, if we discover a material risk factor during the underwriting period, we may:
 - a. Cancel this policy during the underwriting period if you do not meet our underwriting standards; or
 - b. Recalculate your premium from the effective date of the policy if you meet our underwriting standards.

A material risk factor means a risk factor that:

- o Was incorrectly recorded or not disclosed by the insured in an application for insurance;
- o Was in existence on the date of the application; and
- o Modifies estimated annual premium charged on the policy in accordance with the rates and supplementary rating information filed by the carrier

A material risk factor does not include:

- o Information that constitutes a material misrepresentation; or
- o A change initiated by an insured, including any request by the insured that results in a change

in coverage, change in deductible, or other change to a policy.

2. If we recalculate your premium because we discovered a material risk factor during the underwriting period, we will provide to you, by certificate of mailing or by delivery of electronic means in accordance with Md. Code Ann. Ins. §27-601.2, written notice of the following information by no later than the end of the underwriting period:
 - a. The amount of the recalculated premium;
 - b. The reason for the increase or reduction in the premium; and
 - c. Your right to cancel this policy and receive a pro rata refund of any premium paid by notifying us of the cancellation.
3. If you cancel this policy following receipt of a notice of recalculated premium, you will receive a pro rata refund of any premium paid, regardless of whether your policy is a retrospectively rated policy.
4. Nothing in this endorsement prohibits us from conducting an audit in accordance with the provisions of your policy or charging and collecting the final premium based on the results of the audit.
5. This endorsement does not apply if your policy is a renewal policy.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA INSTALLMENT FEE DISCLOSURE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

A service fee of \$7.00 is charged for each installment

when your premium is paid in installments. The service fee is \$5.00 per withdrawal when you select an electronic fund transfer payment plan. The service fee will be added to the premium amount shown on your premium billing statement.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MARYLAND ALCOHOL- AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

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

You may qualify for a premium credit if you have established and maintain an alcohol- and drug-free workplace policy that includes one or more of the qualifying programs included in Section 11-329 of Maryland Code, Insurance.

You may request a premium credit by submitting a written statement to us certifying that you have established and maintain an alcohol- and drug-free workplace policy that includes one or more of the qualifying programs in accordance with Section 11-329 of Maryland Code, Insurance and our filed and approved rating program rules.

We have the right to require additional information to verify that you have established and maintain a qualifying program.

Your certification is required for each policy year that you receive the premium credit.

Your policy is subject to additional premium, for reimbursement of premium credit, and cancellation provisions of the policy if we determine that you misrepresented your compliance with the program rules.

Minimum premium policies are not eligible for this premium credit. The premium credit must not be used to reduce the premium below the minimum premium.

Schedule

Premium Credit % 4%



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.

Countersigned by _____
Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118

BETHESDA MD 20814

Section I of this endorsement expands coverage provided under WC 00 00 00.

Section II of this endorsement provides additional coverage usually only provided by endorsement.

Section III of this endorsement is a Schedule of Covered States.

You may use the index to locate these coverage features quickly:

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SECTION I

PARTS ONE and TWO

1. WE WILL ALSO PAY

D. We Will Also Pay of Part One (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of Part Two (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

We Will Also Pay

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

1. reasonable expenses incurred at our request, **INCLUDING** loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph 4. of **A. How This Insurance**

Applies of Part 3 (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of Part 6 (Conditions) is replaced by the following:

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

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

4. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

5. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental

to work in a state shown in Item 3.A. of the Information Page.

3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and 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 the officer's or employee's employment.

The officer's or 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 as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

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

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

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

E. Recovery From Others

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

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

F. Employers' Liability Insurance

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

This provision 5. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

6. Employers' Liability Stop Gap Coverage

- A. This coverage only applies in Montana, North Dakota, Ohio, Washington, West Virginia and Wyoming.
- B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.
- C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.
- D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief that an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.
 13. bodily injury sustained by any member of the flying crew of any aircraft.
 14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.
- E. This insurance applies to damages for which you are liable under West Virginia Code Annot. S 23-4-2.

SECTION III

7. SCHEDULE OF COVERED STATES

- A. This endorsement only applies in the states listed in this Schedule of Covered States.
- B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

DC, CA, MD

Countersigned by _____ Authorized Representative



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**AMENDMENT TO WORKERS' COMPENSATION BROAD FORM
ENDORSEMENT- EMPLOYERS' LIABILITY STOP GAP COVERAGE**

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

This endorsement changes the Workers'
Compensation Broad Form Endorsement –
Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota,
Ohio, Washington, and Wyoming

E. This paragraph is removed.

6. Employers' Liability Stop Gap Coverage



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

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

Definitions

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

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

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

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

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

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

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - a. \$100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
 - b. \$120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
 - c. \$140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
 - d. \$160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
 - e. \$180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
 - f. \$200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed \$100,000,000,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
See Attached Schedule		



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2015.

Definitions

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

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:
 - a) The act is an act of terrorism.
 - b) The act is violent or dangerous to human life, property or infrastructure.
 - c) The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

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

3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
 - a. \$100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
 - b. \$120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
 - c. \$140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
 - d. \$160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
 - e. \$180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
 - f. \$200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of the Insured Losses that exceeds \$100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

Rate per \$100 of Remuneration



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION

3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

For purposes of this endorsement, the following definitions apply:

- Catastrophe (other than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of \$50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary

of Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:

- a. It is an act that is violent or dangerous to human life, property, or infrastructure;
 - b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
 - c. It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

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

Schedule		
State	Rate	Premium
DC	0.020000	\$0
MD	0.020000	\$288



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

**90-DAY REPORTING REQUIREMENT -
NOTIFICATION OF CHANGE IN OWNERSHIP
ENDORSEMENT**

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

You must report any change in ownership to us in writing within 90 days of the date of the change. Change in ownership includes sales, purchases, other transfers, mergers, consolidations, dissolutions, formations of a new entity and other changes provided for in the applicable experience rating plan. Experience rating is mandatory for all eligible insureds. The experience rating modification factor, if any, applicable to this policy, may change if there is a change in your ownership or in that of one or more of the entities eligible to be combined with you for experience rating purposes.

Failure to report any change in ownership, regardless of whether the change is reported within 90 days of such change, may result in revision of the experience rating modification factor used to determine your premium.

This reporting requirement applies regardless of whether an experience rating modification is currently applicable to this policy.



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

Policy Number: 41 WEC AD7CDH

Endorsement Number:

Effective Date: 08/01/19

Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Address: DIANA DAVIS SPENCER FOUNDATION
3 BETHESDA METRO CTR STE 118
BETHESDA MD 20814

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

SCHEDULE

BOP BESTHESDA METRO CENTER LLC, 3 BESTHESDA 001
METRO CENTER STE 118, BESTHESDA, MA 20814

Countersigned by _____
Authorized Representative



POLICY ADJUSTMENT NOTICE

The premium we charged for your enclosed Hartford policy was based, in part, on estimates and assumptions related to items such as payroll, sales revenue, and the nature of business operations for the policy period shown. When your coverage period expires, a premium audit will be conducted to ensure the premium you paid for your insurance was accurate. In order to complete the premium audit, when your policy coverage period expires you may receive, via e-mail or US Postal mail, a request to complete an "Insured's Report of Exposure" Form. Alternatively, you may receive notice that a Premium Audit representative will be contacting you to review your records and discuss your business operations over the phone or in person. The purpose of the statement, phone call or visit is for the Premium Audit Department to collect the information required to ensure that the premium you paid for your coverage was accurate.

Once the audit is complete, you will receive a Statement of Premium Adjustment which will reflect the amount of your policy auditable premium, and will indicate whether you are owed a refund or if additional premium is due for the policy period shown.

If we owe you a return premium, The Hartford will apply the refund amount to any current account balance. If your account is paid in full, or if your refund amount is greater than the current account balance, we will issue you a refund check. You can expect to receive this check within the next **30** days.

If you owe us an additional premium, the **entire amount** will appear as due and payable on your next bill. This amount will appear as "Premium Audit" on your bill.

If you have any questions regarding the Premium Audit process, please call your insurance agent.

Thank you for doing business with The Hartford.



IMPORTANT NOTICE FOR FLORIDA POLICYHOLDERS

If you would like to present inquiries or obtain information about coverage or obtain assistance in resolving a complaint, please contact YOUR HARTFORD AGENT, or you may contact The Hartford at the number stated below.

SERVICING OFFICE:

THE HARTFORD BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
TELEPHONE: (877) 853-2582

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE BE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.



IMPORTANT NOTICE FOR MARYLAND POLICYHOLDERS

Our Practices Regarding a Policyholder's Claim History

Pursuant to Maryland Insurance Laws, Section 27-501 (n)(2), please be aware that your claims history is considered in the company's decision to cancel or refuse to renew a policy.



PRODUCER COMPENSATION NOTICE

You can review and obtain information on The Hartford's producer compensation practices at www.TheHartford.com or at 1-800-592-5717.



POLICYHOLDER NOTICE YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us - Twin City Fire Insurance Company

- (1) General questions regarding your policy should be directed to **your Hartford Agent or**

Twin City Fire Insurance Company
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
Telephone: (877) 853-2582
www.thehartford.com

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

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

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

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

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

- (2) **Policyholder Information.** Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

- (3) **Experience Rating Form.** Each experience rated risk may receive a single copy of its current Experience Rating Form/Worksheet free of charge by completing a Policyholder Experience Rating Worksheet Request Form on the WCIRB's website at wcirb.com/ratesheet. The Experience Rating Form/Worksheet will include a Loss-Free Rating, which is the experience modification that would have been calculated if \$0 (zero) actual losses were incurred during the experience period. This hypothetical rating calculation is provided for informational purposes only.

II. Dispute Process

You may dispute our actions or the actions of the WCIRB pursuant to CIC Sections 11737 and 11753.1.

A. Our Dispute Resolution Process.

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:

Twin City Fire Insurance Company

One Hartford Plaza, T.4.175, Hartford, CT 06155; Telephone (800) 451-6944; Fax (860) 723-4289.

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether or not your written request will be reviewed. If we agree to review your request, we must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If we decline to review your request, if you are dissatisfied with the decision upon review, or if we fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below.

- B. Disputing the Actions of the WCIRB.** If you have been aggrieved by any decision, action, or omission to act of the WCIRB, you may request, in writing, that the WCIRB reconsider its decision, action, or omission to act. You may also request, in writing, that the WCIRB review the manner in which its rating system has been applied in connection with the insurance afforded or offered you. For requests related to classification disputes, the reporting of experience, or coverage issues, your initial request for review must be received by the WCIRB within 12 months after the expiration date of the policy to which the request for review pertains, except if the request involves the application of the Revision of Losses rule. For requests related to your experience modification, your initial request for review must be received by the WCIRB within 6 months after the issuance, or 12 months after the expiration date, of the experience modification to which the request for review pertains, whichever is later, except if the request for review involves the application of the Revision of Losses rule. If the request involves the Revision of Losses rule, the time to state your appeal may be longer. (See Section VI, Rule 7 of the ERP).

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

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether or not your written request will be reviewed. If the WCIRB agrees to review your request, it must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If the WCIRB declines to review your request, if you are dissatisfied with the decision upon review, or if the WCIRB fails to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below. Written Complaints and Requests for Action should be forwarded to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).

- C. California Department of Insurance – Appeals to the Insurance Commissioner.** After you follow the appropriate dispute resolution process described above, if (1) we or the WCIRB decline to review your request, (2) you are dissatisfied with the decision upon review, or (3) we or the WCIRB fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner pursuant to CIC Sections 11737, 11752.6, 11753.1 and Title 10, California Code of Regulations, Section 2509.40 et seq. You must file your appeal within 30 days after we or the WCIRB send you the notice rejecting review of your Complaint and Request for Action or the decision upon your Complaint and Request for Action. If no written decision regarding your Complaint and Request for Action is sent, your appeal must be filed within 120 days after you sent your Complaint and Request for Action to us or to the WCIRB. The filing address for all appeals to the Insurance Commissioner is:

Administrative Hearing Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco, CA 94105
415.538.4102

You have the right to a hearing before the Insurance Commissioner, and our action, or the action of the WCIRB, may be affirmed, modified or reversed.

III. Resources Available to You in Obtaining Information and Pursuing Disputes

- A. Policyholder Ombudsman.** Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159 (phone), 415.371.5288 (fax) and ombudsman@wcirb.com (email).
- B. California Department of Insurance - Information and Assistance.** Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 800.927.HELP (4357) or insurance.ca.gov. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

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



POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

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

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.
2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.
3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per \$100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.
4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your

premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.

5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.
6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.
7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.
3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.
4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.
6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.
 - (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code 11750.3(c).
 - (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

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



POLICYHOLDER NOTICE

PAYROLL RECORD AND AUDIT REQUIREMENTS FOR DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Your policy includes one or more construction or erection classifications. Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

Payroll Record Requirements

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

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

The non-salaried employee's regular hourly wage shall be determined by dividing that employee's total remuneration by the hours worked during the pay period, irrespective of whether the employee is paid on an hourly, piecework, production or commission basis.

The payroll earned by any non-salaried employees for whom the records specified above are not maintained and/or made available will be assigned to the low wage classification that describes the operations performed.

The regular hourly wage of salaried employees is determined by dividing the total annual remuneration by 2000 hours. If an employee is salaried for less than 12 months, the regular hourly wage for the salaried period is calculated on a prorated basis.

Audit Requirements

If your policy produces a final premium of \$13,000 or more, a physical audit is required at least once a year. If your policy produces a final premium of less than \$13,000 and payroll is developed under a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

If you hold a C-39 Roofing Contractor license from the California Contractors State License Board, a physical audit is required on the complete policy period of each policy regardless of the amount of final premium. See California Insurance Code Section 11665(a) for additional requirements regarding the audit of C-39 license holders.



POLICYHOLDER NOTICE

JANUARY 1, 2015 AUDIT REQUIREMENTS FOR POLICIES WITH FINAL PREMIUM OF LESS THAN \$13,000 THAT DEVELOP PAYROLL IN HIGH WAGE DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specific wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

If your policy effective on or after January 1, 2015 produces a final premium of less than \$13,000 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. If your policy produces a final premium of \$13,000 or more, a physical audit is required at least once a year.

A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.



CALIFORNIA NOTICE

CALIFORNIA LABOR CODE 3551 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS CODE, EXCEPT EMPLOYERS OF EMPLOYEES DEFINED IN SUBDIVISION (d) OF SECTION 3351, SHALL GIVE EVERY NEW EMPLOYEE, EITHER AT THE TIME OF HIRE, OR BY THE END OF THE FIRST PAY PERIOD, WRITTEN NOTICE OF THE INFORMATION CONTAINED IN SECTION 3550.

CALIFORNIA LABOR CODE 3550 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS DIVISION SHALL POST AND KEEP POSTED IN A CONSPICUOUS LOCATION FREQUENTED BY EMPLOYEES, AND WHERE THE NOTICE MAY BE EASILY READ BY EMPLOYEES DURING THE HOURS OF THE WORKDAY, A NOTICE WHICH SHALL STATE THE NAME OF THE CURRENT COMPENSATION INSURANCE CARRIER OF THE EMPLOYER, OR WHEN SUCH IS THE FACT, THAT THE EMPLOYER IS SELF-INSURED, AND WHO IS RESPONSIBLE FOR CLAIMS ADJUSTMENT.



NOTICE TO POLICYHOLDER

CALIFORNIA WORKERS' COMPENSATION

INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws applicable to new and renewal policies with policy effective dates on and after January 1, 1995.

1. The laws requiring all insurers to charge the same minimum rate uniformly to all employers within a given classification has been repealed. Beginning January 1, 1995, we will establish our own rates for workers' compensation. Our rates will not be applicable prior to the first normal policy effective date of a policy incepting on or after January 1, 1995. Our rates, rating plans and related information are filed with the Insurance Commissioner and are open for public inspection.
2. The Insurance Commissioner can disapprove our rates, rating plans or classifications only if he has determined after public hearing that our rates might jeopardize our ability to pay claims or create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance Commissioner disapproves our rates, rating plans or classification, he may order an increase in the rates applicable to outstanding policies.
3. Rating organizations may develop pure premium rates which are subject to the Insurance Commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per \$100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to sue the pure premium rates developed by any rating organization in establishing our own rates.
4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan developed by the insurance rating organization designated by the Insurance commissioner is subject to the approval of the Insurance Commissioner.
5. A standard classification system developed by the insurance rating organization designated by the Insurance Commissioner is subject to approval of the Insurance Commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided that we can report the payroll, expenses and other costs of claims in a way which is consistent with the standard classification system.
6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.
7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process will require us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the Insurance Commissioner.



IMPORTANT NOTICE TO OUR POLICYHOLDERS

As required by Florida law, statute number 440.381, paragraph 4, you are required to file with your insurance carrier on a quarterly basis: UCT-6 and a current list of employees.

Failure to do so, could result in your policy being cancelled.

If you have any questions, please contact your Insurance Agent.



IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized \$2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

- () 1. I reject this deductible option and elect that the company pay all benefits due under my policy.
- () 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 41 WEC AD7CDH		
Employer Name DIANA DAVIS SPENCER FOUNDATION	Date	Signature and Title
Agent Name LOCKTON COMPANIES LLC	Date	Signature

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

☐ Job applicant

☐ Routine fitness for duty

☐ Reasonable suspicion

☐ Follow-up testing to
Employee Assistance Program

Notice of Employer's Drug Testing Policy:

☐ Copy to all employees prior to testing

☐ Show notice of drug testing on vacancy
announcements

☐ Posted on employer's premises

☐ Copies available in personnel office or
other suitable locations

☐ Copy to job applicants prior to testing

☐ No notice required because the
employer had a drug testing program
in place prior to July 1, 1990

☐ General notice given 60 days prior to testing

Education:

☐ Resource file on providers

☐ Employee Assistance Program

☐ Education

Name of Medical Review Officer: _____

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

B. Phone No.: () _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employer Name

Date

Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

Notary Public's Signature

Date

Expiration of Commission

Division of Workers' Compensation

IMPORTANT WORKERS' COMPENSATION INFORMATION FOR CONTRACTORS

Coverage Requirements

- 1) A contractor or sub-contractor who is engaged in the construction industry and employs one or more employees must have Florida workers' compensation insurance. Corporate officers, in addition to limited liability company members, sole proprietors, partners, and independent contractors engaged in the construction industry are considered employees under Florida's workers' compensation law. However, a contractor or sub-contractor who is engaged in the construction industry and is a corporate officer or a member of a limited liability company can apply for and obtain a valid construction industry exemption. Workers' compensation insurance is still required for the contractor's or subcontractor's employees.
- 2) A contractor shall require any sub-contractor who sub-contracts work from a contractor to provide evidence of Florida workers' compensation insurance. If the sub-contractor has a valid exemption, then the subcontractor shall also provide a copy of his or her certificate of exemption to the contractor.
- 3) A change in job duties performed by employees or an increase in the amount of payroll of a business must be reported to the insurance company.
- 4) If a contractor has secured workers compensation coverage for his or her employees by entering into an employee leasing arrangement, the contractor must specifically identify coverage for each and every employee. The contractor must notify the employee leasing company of the names of all the covered employees and any additional employees that are working on a jobsite that may have been excluded from the employee leasing arrangement. Any change in job duties performed by the employees must also be reported to the employee leasing company.
- 5) Please see the reverse side of this flyer for information about obtaining worker's compensation insurance and for the eligibility requirements for a construction industry exemption.

Out-Of-State Contractors

- 1) An out-of-state contractor must immediately notify his or her insurance company and, or insurance agent that it has employees that are engaging in work in Florida.
- 2) An out-of-state construction industry contractor who has employees engaged in work in Florida, must either obtain a Florida workers' compensation insurance policy or an endorsement must be added to the out-of-state contractor's policy that lists Florida in section 3.A. of the policy.
- 3) A Florida construction contractor engaged in work in this state who contracts with out-of-state contractors, must require proof of a Florida workers' compensation policy or an endorsement to the out-of-state contractor's policy that lists Florida in section 3.A. of the policy. If the out-of-state subcontractor does not provide proof of a Florida workers' compensation policy or of an endorsement to the policy, or does not have a valid workers' compensation exemption; the Florida contractor must contact his or her workers' compensation insurance carrier to update his or her policy to include such sub-contractor and any persons that are employed by such sub-contractor.

Enforcement Provisions

- 1) The Florida Division of Workers' Compensation is responsible for enforcing employer compliance with the coverage requirements of the workers' compensation law. Compliance investigators have the authority to conduct on-site inspections of job sites to ensure employer compliance. Investigators can also request an employer's business records. An employer must produce the required business records within five business days of the division's written request for records. If the employer fails to respond to the request within five business days, the division will issue a stop work order upon the employer requiring the employer to cease all business operations in the state.

- 2) A stop work order will also be issued to any employer who is required to secure Florida workers' compensation coverage but fails to do so. A stop work order will also be issued in cases where an employer may have a workers' compensation policy but understates or conceals payroll, misrepresents or conceals employee duties or fails to utilize Florida's class codes and workers' compensation rates.
- 3) In order for the division to release a stop work order, an employer must provide evidence that it has come into compliance and it has paid the monetary penalty.

Where to Find Workers Compensation Insurance Coverage?

Contact an insurance agent. You can also contact the following insurance agent associations:

- o Florida Association of Insurance Agents at 850-893-4155
- o Professional Insurance Agents of Florida at 800-277-1171
- o Latin American Association of Insurance Agency at 305-477-1442

If you cannot obtain coverage through the standard workers' compensation market, you may contact the Florida Workers' Compensation Joint Underwriting Association (FWCJUA) at 941-378-7400 or visit their website at www.fwcjua.com. The workers' compensation rates in the FWCJUA will be higher than the rates in the standard market.

You may also consider entering into an employee leasing arrangement with a professional employer organization that has secured workers' compensation coverage on behalf of its clients.

How to Obtain a Construction Industry Exemption Application?

For additional information about workers' compensation coverage and the location of district offices nearest to you to obtain an exemption application, please call 1-800-742-2214.

You can download an exemption application and the

instructions for completing it at the Division of Workers' Compensation website, which is www.fldfs.com/WC/forms.html. Click on forms "DWC 250" and "DWC 250 Instructions".

Construction Industry Exemption Eligibility Information

You must be an officer of a corporation or a member of a limited liability company (LLC). However, an officer of a corporation who elects to be exempt may not recover workers' compensation benefits.

You must show proof that you own at least 10% of the corporation or company.

****Your corporation or LLC must be registered with the Florida Department of State, Division of Corporations.**

You must be listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.

You must list all certified or registered licenses issued to you pursuant to Chapter 489, Florida Statutes.

You must provide a copy of a current occupational license required by the city or county in which the business is located or performing regular work.

No more than three officers of a corporation (including LLC) or of any group of affiliated corporations (including LLCs) may elect to be exempt.

A \$50.00 application fee is required if you are applying for a construction industry exemption.

****Out-of-state contractors that are corporations or limited liability companies can qualify as foreign corporations or foreign limited liability companies by filing specific forms and documentation with the Florida Division of Corporations. For more Information regarding the foreign qualification requirements, call (850) 245-6051. The forms can be accessed at www.sunbiz.org.**

DIVISION OF
DWC
WORKERS' COMPENSATION
Tom Gallagher, Chief Financial Officer



Reporting a Work-Related Injury is Time Sensitive!

Call The Hartford's LossConnect immediately to report a claim.

1-800-327-3636

Available 24 hours a day, 365 days a year.

The Benefits of Timely Loss Reporting:

Research has shown that faster loss reporting significantly affects loss costs. The sooner we are notified, the sooner we can investigate the accident and coordinate with you, the injured employee, and the medical team to ensure the fastest possible return to health and work.

The Effect of Timely Reporting on Controlling the Cost of Your Loss:

Average Loss for Closed Claims (Accident Years 2002-2005)	
Report Lag in Days	Percent Change in Loss Costs Compared to First Week Report
Incident Day	-6%
Week 1	0%
Week 2	13%
Week 3 or 4	16%
1 Month or Later	24%

Statutory requirements also necessitate the prompt initial reporting of the accident causing injury or death. Failure to comply may result in a fineable offense by the State.

Information You'll Need

Company Information

- o Account Number
- o Location Code (if applicable)
- o Parent Company (or program name)
- o Policy Number

Worker Information

- o Name, DOB, Address, Phone
- o Social Security Number
- o Age, Gender
- o Marital Status, Number of Dependents
- o Hire Date, Years in Current Position
- o Wage Information

Incident Information

- o Type of injury (burn, cut, etc.)?
- o Exact body part injured?
- o What caused the accident?
- o Any reason to question the injury?
- o Any witnesses?
- o Address where injury occurred?
- o Where was the injured employee treated? (Provide name, address, phone of medical provider.)
- o When was the accident reported to you and by whom (date, time)?

Network Providers

A listing of more than 400,000 network providers qualified to treat work-related injuries is available online at www.talispoint.com/hartext or by calling our Network Referral Unit at 1-800-327-3636 (select 4 at the prompt). Since network referrals are often impacted by state specific rules, please call to learn how to maximize our network capabilities on behalf of your employees.

Maryland Alcohol- and Drug-Free Workplace Premium Credit Employer Certification Form

The Hartford* offers a 4% credit to Maryland employers that establish and maintain qualifying alcohol and drug free workplace programs. An employer may receive a credit by submitting a written statement certifying that the employer has established and maintains an alcohol and drug free workplace policy that includes one or more of the qualifying programs found in section 11-329(f)(3) of the Maryland statutes.

A 4% credit will be granted to Maryland employers that establish and maintain qualifying alcohol and drug free workplace programs in accordance with section 11-329(f)(3) of the Maryland statutes.

The qualifying programs found in section 11-329(f)(3) of the Maryland statutes are:

- o Alcohol and drug testing program
- o Employee education program on alcohol and drug abuse
- o Supervisor education program on alcohol and drug abuse
- o Employee assistance program that includes referrals of employees for appropriate diagnosis, treatment and assistance
- o Program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing
- o Any other program the insurer deems effective to encourage an alcohol and drug free Workplace

To qualify for a credit, the employer must provide a written copy or copies of the employer's above noted alcohol and drug testing program, employee education program, supervisor education program, employee assistance program, and/or post-accident alcohol and drug testing requirement.

To qualify for a credit, the employer must provide a copy of an agreement with an outside entity to conduct the alcohol and drug testing services regarding qualifying program shown in first bullet above.

The employer's program(s) must be in accordance with Maryland statutes and any rating plan rules established by the carrier and approved by the Maryland Insurance Administration.

An employer may request a premium credit by submitting a written statement to The Hartford certifying that the employer has established and maintains an alcohol- and drug-free workplace policy that includes one or more of the qualifying programs found in section 11-329(f)(3) of the Maryland statutes.

The Hartford will not provide a premium credit if the employer is required under federal or state law to test its employees for drugs or otherwise provide an alcohol- and drug-free workplace.

The Hartford will apply the premium credit to the employer's policy pro rata from the date that the employer's certification is received by the carrier.

The premium credit must be based on evidence contained in our file at the time that the credit is allowed. The Hartford may require additional information from the employer to verify that the employer has established and maintains a qualifying program.

An employer certification is required for each policy year that the employer receives a premium credit.

* The Hartford means Hartford Fire Insurance Company and its property & casualty affiliates.

Maryland Alcohol- and Drug-Free Workplace Premium Credit Employer Certification Form

To Apply for a Credit:

- 1.) Complete the Employer information listed below.

Employer Name:

Employer Address:

Employer City, State, Zip:

Policy Number and Effective Date:

- 2.) Circle the qualifying programs listed below that have been established and are maintained by your company. Written copies of the circled items must be provided with this certification form in order to qualify for a credit. A written copy of an agreement with an outside entity to conduct alcohol and drug testing is required to qualify for a credit if item "A" is selected below.

- A. Alcohol and drug testing program
- B. Employee education program on alcohol and drug abuse
- C. Supervisor education program on alcohol and drug abuse
- D. Employee assistance program that includes referrals of employees for appropriate diagnosis, treatment and assistance
- E. Program requiring an employee who has caused or contributed to an accident while at work to undergo alcohol or drug testing
- F. Any other program the insurer deems effective to encourage an alcohol and drug free Workplace

- 3.) Sign and date the certification form in the space provided below. Return the certification form to The Hartford along with written copies of items as required under item 2 above.

Completed by:

Print Name

Signature

Title:

Date:



Customer Privacy Notice
The Hartford Financial Services Group, Inc. and Affiliates*
(herein called "we, our, and us")

This Privacy Policy applies to our United States Operations

We value your trust. We are committed to the responsible:

- a) management;
 - b) use; and
 - c) protection;
- of **Personal Information**.

This notice describes how we collect, disclose, and protect **Personal Information**.

We collect **Personal Information** to:

- a) service your **Transactions** with us; and
- b) support our business functions.

We may obtain **Personal Information** from:

- a) **You**;
- b) your **Transactions** with us; and
- c) third parties such as a consumer-reporting agency.

Based on the type of product or service **You** apply for or get from us, **Personal Information** such as:

- a) your name;
 - b) your address;
 - c) your income;
 - d) your payment; or
 - e) your credit history;
- may be gathered from sources such as applications, **Transactions**, and consumer reports.

To serve **You** and service our business, we may share certain **Personal Information**. We will share **Personal Information**, only as allowed by law, with affiliates such as:

- a) our insurance companies;
- b) our employee agents;
- c) our brokerage firms; and
- d) our administrators.

As allowed by law, we may share **Personal Financial Information** with our affiliates to:

- a) market our products; or
 - b) market our services;
- to **You** without providing **You** with an option to prevent these disclosures.

We may also share **Personal Information**, only as allowed by law, with unaffiliated third parties including:

- a) independent agents;
- b) brokerage firms;

- c) insurance companies;
 - d) administrators; and
 - e) service providers;
- who help us serve **You** and service our business.

When allowed by law, we may share certain **Personal Financial Information** with other unaffiliated third parties who assist us by performing services or functions such as:

- a) taking surveys;
- b) marketing our products or services; or
- c) offering financial products or services under a joint agreement between us and one or more financial institutions.

We, and third parties we partner with, may track some of the pages **You** visit through the use of:

- a) cookies;
 - b) pixel tagging; or
 - c) other technologies;
- and currently do not process or comply with any web browser's "do not track" signal or other similar mechanism that indicates a request to disable online tracking of individual users who visit our websites or use our services.

For more information, our Online Privacy Policy, which governs information we collect on our website and our affiliate websites, is available at <https://www.thehartford.com/online-privacy-policy>.

We will not sell or share your **Personal Financial Information** with anyone for purposes unrelated to our business functions without offering **You** the opportunity to:

- a) "opt-out;" or
 - b) "opt-in;"
- as required by law.

We only disclose **Personal Health Information** with:

- a) your authorization; or
- b) as otherwise allowed or required by law.

Our employees have access to **Personal Information** in the course of doing their jobs, such as:

- a) underwriting policies;
- b) paying claims;
- c) developing new products; or
- d) advising customers of our products and services.

We use manual and electronic security procedures to maintain:

- a) the confidentiality; and
- b) the integrity of;

Personal Information that we have. We use these procedures to guard against unauthorized access.

Some techniques we use to protect **Personal Information** include:

- a) secured files;
- b) user authentication;
- c) encryption;
- d) firewall technology; and
- e) the use of detection software.

We are responsible for and must:

- a) identify information to be protected;
- b) provide an adequate level of protection for that data;
- c) grant access to protected data only to those people who must use it in the performance of their job-related duties.

Employees who violate our privacy policies and procedures may be subject to discipline, which may include termination of their employment with us.

We will continue to follow our Privacy Policy regarding **Personal Information** even when a business relationship no longer exists between us.

As used in this Privacy Notice:

Application means your request for our product or service.

Personal Financial Information means financial information such as:

- a) credit history;
- b) income;
- c) financial benefits; or
- d) policy or claim information.

Personal Financial Information may include Social Security Numbers, Driver's license numbers, or other government-issued identification numbers, or credit, debit card, or bank account numbers.

Personal Health Information means health information such as:

- a) your medical records; or
- b) information about your illness, disability or injury.

Personal Information means information that identifies **You** personally and is not otherwise available to the public. It includes:

- a) **Personal Financial Information**; and
- b) **Personal Health Information**.

Transaction means your business dealings with us, such as:

- a) your **Application**;
- b) your request for us to pay a claim; and
- c) your request for us to take an action on your account.

You means an individual who has given us **Personal Information** in conjunction with:

- a) asking about;
 - b) applying for; or
 - c) obtaining;
- a financial product or service from us if the product or service is used mainly for personal, family, or household purposes.

If you have any questions or comments about this privacy notice, please feel free to contact us at The Hartford - Law Department, Privacy Law, One Hartford Plaza, Hartford, CT 06155, or at CorporatePrivacyOffice@thehartford.com.

This Customer Privacy Notice is being provided on behalf of The Hartford Financial Services Group, Inc. and its affiliates (including the following as of March 2018), to the extent required by the Gramm-Leach-Bliley Act and implementing regulations.

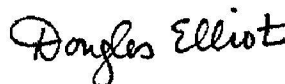
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POLICY NUMBER: 41 WEC AD7CDH

Our President and Secretary have signed this policy. Where required by law, the Information Page has been countersigned by our duly authorized representative.



Lisa Levin, Secretary



Douglas Elliot, President

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