TEXAS

NOTICE OF ACCIDENT PREVENTION SERVICES

Pursuant to Texas Labor Code §411.066, The Travelers Companies, Inc. is required to notify its policyholders that accident prevention services are available from The Travelers Companies, Inc. at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. The Travelers Companies, Inc. 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 Travelers Companies, Inc. at (281) 606-8530 and rfeemste@travelers.com for accident prevention services or (281) 606-8530 and rfeemste@travelers.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 (512) 804-5000. If The Travelers Companies, Inc. 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, P.O. Box 12050, Austin, Texas 78711;

Notice To Policy Recipient:

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

NEW YORK SECURITY FUND SURCHARGE

Dear Policyholder:

"Companies writing workers compensation insurance business in New York are required to participate in the New York Workers' Compensation Security Fund. If a company becomes insolvent, the security fund settles unpaid claims and assesses each insurance company for its fair share.

New York law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged "NY surcharge", an amount will be displayed on your premium notice."

DATE OF ISSUE: 01-08-25

W31N2E04

SAFETY SERVICES

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

SAFETY IS OUR CONCERN

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

An important part of that service concerns safety and accident prevention. Travelers Risk Control has an extensive staff of safety and loss prevention professionals assisting customers across the country and around the world. We have one of the largest Risk Control departments in the industry, and our scale allows us to apply the right resource at the right time to meet customer needs.

We have a wide range of industry-specific experience, which includes manufacturing, construction, wholesale and retail businesses, service organizations, technology-related business, the oil and gas industry, the public sector and others.
Following are some examples of available safety services:

Accident Prevention – Our staff can help you address hazards within your operations, premises and equipment, and recommend solutions for reducing or eliminating these hazards.

Analysis of Accident Causes – Our REACT accident investigation program can assist you in determining root causes of accidents and help you prevent recurrences.

Safety Consultations – Our consultants can assist you with solutions in specialized areas such as ergonomics, industrial hygiene and fleet safety.

Industrial Hygiene/Health Services – Travelers has an AIHA accredited lab to analyze air samples taken by our IH Specialists, or by you, through our Pump Loan program to help you identify potential exposures to occupational illnesses.

Safety Literature and Digital Media – Our Risk Control customer website has hundreds of resources including checklists, sample programs, self-assessments, instructional videos and other safety and health related tools.

Safety Training – We offer face-to-face classroom courses, as well as distance learning and online training programs on a variety of safety and risk management topics in order to provide flexibility for your safety training needs.

Return-To-Work Coordination – We have consultants who specialize in post injury management that can assist you with developing or enhancing a return-to-work program, along with other aspects of our Corridor of Care® post injury process.

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

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

SAFETY IS YOUR CONCERN

At Travelers, we are committed to helping protect your business. Travelers Risk Control has the experience, resources and capabilities to provide a range of safety services Onsite, Online and On-Demand. As our customer, you have access to hundreds of safety resources that cover an array of safety and risk management topics to help you control hazards and reduce risks of injury or illness. You can access these resources by logging in at www.travelers.com. Not registered? Select "Log In" and then "Register Now" to register for MyTravelers for Business.

The loss of a key employee due to an injury can seriously impact your business. We can help you to understand the types of accidents that may occur in your business and the steps you can take to help prevent them.

Examples of what you will find include:

- Safety checklists, sample programs and self-assessments.
- Safety training offerings including classroom, and online.
- Additional safety products and services

These resources can help you improve your workplace safety practices.

Contact Us

For more information, please visit travelers.com/riskcontrol or contact your local Travelers office.

Please call these numbers
FOR SAFETY SERVICES ONLY
For all other inquiries please contact your agent, underwriter or claim representative

ALABAMA
Birmingham
3000 Riverchase Galleria
Ste. 600
Birmingham, AL 35244
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

ALASKA
Portland, OR
4000 SW Kruse Place, Suite 100
Lake Oswego, OR 97035
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

ARIZONA
Phoenix
2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

ARKANSAS
Kansas City, KS
7465 West 132nd, Suite 400
Overland Park, KS 66213
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Diamond Bar
21688 Gateway Center Drive
P.O. Box 6512
Diamond Bar, CA 91765-8512
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Glendale
655 N. Central Avenue, Suite 1600
Glendale, CA 91203
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Irvine
3333 Michelson Dr. City Blvd. W
Suite 1000
Irvine, CA 92612
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Los Angeles
888 South Figueroa St., Ste. 500
Los Angeles, CA 90017
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Sacramento
11070 White Rock Road, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
San Diego
9325 Sky Park Court, Suite 220
San Diego, CA 92123
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CALIFORNIA
Walnut Creek
401 Lennon Lane, Suite 100
Walnut Creek, CA 94598
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

COLORADO
Denver
6060 S. Willow Dr. #300
Greenwood Village, CO 80111
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

CONNECTICUT
Hartford
300 Windsor Street
Hartford, CT 06120
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

DELAWARE
Philadelphia, PA
10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

DISTRICT OF COLUMBIA
Washington, DC
14200 Park Meadow Dr.
Chantilly, VA 20151
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

FLORIDA
Orlando
2420 Lakemont Dr
Orlando, FL 32814
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

GEORGIA
Atlanta
1000 Windward Concourse
Alpharetta, GA 30005
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

HAWAII
Irvine, CA
3333 Michelson Drive City Blvd. W
Suite 1000
Irvine, CA 92612
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

IDAHO
Sacramento, CA
11070 White Rock Rd, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

ILLINOIS
Chicago
161 N Clark St.
Suite 900
Chicago, IL 60601
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

ILLINOIS
Naperville
215 Shuman Boulevard
P.O. Box 3208
Naperville, IL 60566
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

INDIANA
Indianapolis
Suite 300
280 East 96th Street
Indianapolis, IN 46240
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

IOWA
Des Moines
7101 Vista Dr.
West Des Moines, IA 50266-9313
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

KANSAS CITY
7465 West 132nd, Suite 400
Overland Park, KS 66213
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

Please call these numbers
FOR SAFETY SERVICES ONLY
For all other inquiries please contact your agent, underwriter or claim representative

KENTUCKY
Louisville
Suite 150
303 N Hurstbourne Pkwy
Louisville, KY 40222
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

LOUISIANA
New Orleans
3838 N. Causeway, Suite 2700
Metairie, LA 70002
P.O. Box 61479
New Orleans, LA 70161-1479
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MAINE
Portland, ME
207 Larrabee Road, Suite 3
Westbrook, ME 04092
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MARYLAND
Blue Bell, PA
10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MASSACHUSETTS
Boston
100 Summer Street, Suite 201A
Boston, MA 02110
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MASSACHUSETTS
Hudson
1 Cabot Road
Suite 250
Hudson, MA 01749
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MASSACHUSETTS
Braintree
350 Granite Street
Suite 1201
Braintree, MA 02184
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MICHIGAN
Grand Rapids
625 Kenmoor Ave
Suite 213
Grand Rapids, MI 49546
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MICHIGAN
Troy
1441 W. Long Lake Rd., Ste. 300
Troy, MI 48098
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MINNESOTA
St. Paul
385 Washington St., MC 104P
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MISSISSIPPI
Jackson
1080 River Oaks Dr
Ste B-200
Flowood, MS 39232
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MISSOURI
St. Louis
940 West Port Plaza, Suite 270
St. Louis, MO 63146
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MISSOURI WORKERS' COMPENSATION PLAN (MWCP)
4801 Main Street, Suite 350
Kansas City, MO 64112
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

MONTANA
Sacramento, CA
11070 White Rock Rd, Suite 130
Rancho Cordova, CA 95670
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEBRASKA
Omaha
11516 Miracle Hills Dr., St. 400
Omaha, NE 68154
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEVADA
Las Vegas
7450 Arroyo Crossing Pkwy
Suite 200
Las Vegas, NV 89113
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW HAMPSHIRE
Portland, ME
207 Larrabee Road, Suite 3
Westbrook, ME 04092
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW JERSEY
Morristown
445 South Street
Morristown, NJ 07960
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW JERSEY
Marlton
Lake Center Exec Park Building 30
Suite 110
Marlton, NJ 08053
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW MEXICO
Phoenix
2401 W Peoria Ave., Suite 130
Phoenix, AZ 85029
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW YORK
Albany
900 Watervliet-Shaker Road
Albany, NY 12205
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW YORK
Buffalo
60 Lakefront Blvd.
P.O. Box 242
Buffalo, NY 14240-0242
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW YORK
Melville
3 Huntington Quadrangle
Melville, NY 11747
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW YORK
New York
485 Lexington Ave.
New York, NY 10017-2630
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

Please call these numbers
FOR SAFETY SERVICES ONLY
For all other inquiries please contact your agent, underwriter or claim representative

NEW YORK
Rochester
75 Town Centre Drive
P.O. Box 23235
Rochester, NY 14692-3235
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NEW YORK
Syracuse
440 South Warren Street
P.O. Box 4963
Syracuse, NY 13221-4963
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NORTH CAROLINA
Charlotte
11440 Carmel Commons Blvd.
Suite 400
Charlotte, NC 28226
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NORTH CAROLINA
Raleigh
4504 Emperor Blvd.
Durham, NC 27703
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

NORTH DAKOTA
St. Paul, MN
385 Washington St., MC 104P
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

OHIO
Cincinnati
Baldwin Center, Suite 500
625 Eden Park Drive
Cincinnati, OH 45202
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

OHIO
Cleveland
6150 Oak Tree Blvd., Suite 400
Independence, OH 44131
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

OKLAHOMA
Tulsa
9820 East 41st St., Suite 401
P.O Box 3510
Tulsa, OK 74101
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

OREGON
Portland
4000 SW Kruse Way Place,
Building 1, Suite 255
Lake Oswego, OR 97035
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

PENNSYLVANIA
Philadelphia
10 Sentry Parkway, Suite 300
Blue Bell, PA 19422
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

PENNSYLVANIA
Pittsburgh
112 Washington Place, Suite 910
Pittsburgh, PA 15219
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

PENNSYLVANIA
Reading
1105 Berkshire Blvd.
P.O. Box 13426
Wyomissing, PA 19610
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

RHODE ISLAND
Braintree
350 Granite Street
Suite 1201
Braintree, MA 02184
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

SOUTH CAROLINA
Charlotte
11440 Carmel Commons Blvd.
P.O. Box 473500
Charlotte, NC 28247-3500
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

SOUTH DAKOTA
St. Paul, MN
385 Washington St.
St. Paul, MN 55102
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

TENNESSEE
Franklin
6640 Carothers Pkwy, Suite 300
Franklin, TN 37067
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

TEXAS
Dallas
1301 E Collins Blvd., Suite 300
Richardson, TX 75081
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

TEXAS
Houston
4650 Westway Park Blvd., Suite 350
Houston, TX 77041
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

UTAH
Denver, CO
6060 S. Willow Drive#300
Greenwood Village , CO 80111
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

VERMONT
Hartford, CT
300 Windsor Street
Hartford, CT 06120
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

VIRGINIA
Richmond
9954 Mayland Drive, Suite 6100
Richmond, VA 23233
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

Washington, DC
14200 Park Meadow Dr.
Chantilly, VA 20151
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

WASHINGTON
Seattle
1501 4th Avenue, Suite 400
Seattle, WA 98101
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

WEST VIRGINIA
Charleston, WV
119 Virginia St. W.
Charleston, WV 25302
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

WISCONSIN
Milwaukee
13935 Bishops Drive, Suite 200
Brookfield, WI 53005
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

WYOMING
Denver, CO
6060 S. Willow Drive #300
Greenwood Village, CO 80111
Risk Control: 1-800-973-9215
Claims: 800-238-6225 or travelers.com/claim

TRAVELERS

Report Claims Immediately by Calling*
1-800-238-6225
Speak directly with a claim professional
24 hours a day, 365 days a year

*Unless Your Policy Requires **Written** Notice or Reporting

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

A Custom Insurance Policy Prepared for:

WILKES UNIVERSITY
84 WEST SOUTH STREET
WILKES-BARRE PA 18766

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V **INFORMATION PAGE WC 00 00 01 (A)**

POLICY NUMBER: UB-1T152983-25-14-G

NJ TAX IDENTIFICATION NO.: 240795506000 RENEWAL OF (UB-1T152983-24-14-G)

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA
A Stock Company

NCCI CO CODE: 13579

1.

INSURED:
WILKES UNIVERSITY
84 WEST SOUTH STREET
WILKES-BARRE, PA 18766

PRODUCER:
RIGGS COUNSELMAN MICHAEL
555 FAIRMOUNT AVE
TOWSON, MD 212865417

Insured is **NOT FOR PROFIT**

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

2. The policy period is from **02-15-25** to **02-15-26** 12:01 A.M. at the insured's mailing address.

3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:
AK AL AZ CA CO CT DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS NC NH NJ NM NV NY OK OR RI SC TN TX VA VT WI WV

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:

AR DC MT NE PA SD UT

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

DATE OF ISSUE: 01-08-25 RS
OFFICE: BALTIMORE, MD 008
PRODUCER: RIGGS COUNSELMAN MICHAEL CYQ36

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION SCHEDULE:

CLASSIFICATIONS	CODE NO	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 8221 NAICS: 611310

		STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	$	12053
LOSS CONSTANT		20
PREMIUM DISCOUNT		134
0900-20 EXPENSE CONSTANT		250
TERRORISM		430
CAT (OTHER THAN CERT ACTS OF TERRORISM)		154
TOTAL ESTIMATED PREMIUM		12773
TAXES AND SURCHARGES		272
DEPOSIT AMOUNT DUE		13045

Minimum Premium: $ 500 EMPLOYERS LIABILITY MINIMUM: $150

STOPGAP MINIMUM: $150

DATE OF ISSUE: 01-08-25 RS
OFFICE: BALTIMORE, MD 008
PRODUCER: RIGGS COUNSELMAN MICHAEL CYQ36 COUNTERSIGNED-AGENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **15318-AK**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
AK- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.54	0
AK MANUAL PREMIUM $ 0				

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-AL**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 28 BAY POINTE CT FAIRHOPE , AL 36532 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL (COUNTY/TOWN CODE 0095)	8868	IF ANY	0.55	0

AL MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY COMPANY OF CONNECTICUT

INSURED'S NAME: WILKES UNIVERSITY **27405-AZ**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 245 W 2ND ST MESA , AZ 85201 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	314795.00	0.22	693

AZ MANUAL PREMIUM $ 693

65.00% COMPANY DEVIATION DEBIT(9039)	$ 450
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	13
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	1156
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	1156
-1.60% PREMIUM DISCOUNT(0063)	-18
TERRORISM(9740)	54
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	54
TOTAL ESTIMATED PREMIUM	1246
TOTAL PREMIUM	1246
DEPOSIT AMOUNT DUE	1246

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA 084 003

INSURED'S NAME: WILKES UNIVERSITY **13579-CA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **432 HILLSIDE LN** **SANTA MONICA , CA 90402** **NAICS: 611310**				
COLLEGES OR SCHOOLS-PRIVATE-NOT AUTOMOBILE SCHOOLS-PROFESSORS, TEACHERS OR ACADEMIC PROFESSIONAL EMPLOYEES	**8868**	**97726.00**	**0.761**	**744**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **1600 S COURTNEY AVE** **FULLERTON , CA 92833** **NAICS: 611310**				
COLLEGES OR SCHOOLS-PRIVATE-NOT AUTOMOBILE SCHOOLS-PROFESSORS, TEACHERS OR ACADEMIC PROFESSIONAL EMPLOYEES	**8868**	**IF ANY**	**0.761**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **5739 CORTEEN PL** **VALLEY VILLAGE , CA 91607** **NAICS: 611310**				
COLLEGES OR SCHOOLS-PRIVATE-NOT AUTOMOBILE SCHOOLS-PROFESSORS, TEACHERS OR ACADEMIC PROFESSIONAL EMPLOYEES	**8868**	**IF ANY**	**0.761**	**0**
LOCATION 004 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **CA- NO BUSINESS LOCATION**				
COLLEGES OR SCHOOLS-PRIVATE-NOT AUTOMOBILE SCHOOLS-PROFESSORS, TEACHERS OR ACADEMIC PROFESSIONAL EMPLOYEES	**8868**	**IF ANY**	**0.761**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CA MANUAL PREMIUM $ 744

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 744
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	744
-0.90% PREMIUM DISCOUNT(0064)	-7
TERRORISM(9740)	29
TOTAL ESTIMATED PREMIUM	766
1.237% WC ADMIN REVOLVING FUND ASSESSMENT	9
0.4096% STATE FRAUD SURCHARGE	3
0.0818% UNINSURED EMPLOYERS BENEFIT TRUST FUND ASST	1
3.0148% SUBSEQUENT INJURY BENEFIT TRUST FUND ASST	23
0.1885% OCCUPATIONAL SAFETY & HEALTH FUND ASSESSMENT	1
0.1058% LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT	1
TOTAL PREMIUM	804
DEPOSIT AMOUNT DUE	804

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-CO**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **4017 N CLAY ST** **DENVER , CO 80211** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**83444.00**	**0.64**	**534**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **122 VISTA LN** **LOUISVILLE , CO 80027** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.64**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
18900 E 121ST PL COMMERCE CITY , CO 80022 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.64	0
LOCATION 004				
FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
1410 WILDWOOD RD FORT COLLINS , CO 80521 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.64	0

CO MANUAL PREMIUM $ 534

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	540
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	540
-0.90% PREMIUM DISCOUNT(0064)	-5
TERRORISM(9740)	3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	5
TOTAL ESTIMATED PREMIUM	543
TOTAL PREMIUM	543
DEPOSIT AMOUNT DUE	543

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-CT**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY CT- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	29172.00	0.62	181
LOCATION 002 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 22 KENDALL CT NORWALK , CT 06850 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.62	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CT MANUAL PREMIUM $ 181

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	183
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	183
-0.90% PREMIUM DISCOUNT(0064)	-2
TERRORISM(9740)	4
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	187
2.25% CT SECOND INJURY FUND SURCHARGE	4
2.20% CT WC FUND ASSESSMENT (STATE ACT)	4
3.10% CT WC FUND ASSESSMENT (FEDERAL ACT)	0
TOTAL PREMIUM	195
DEPOSIT AMOUNT DUE	195

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **15245-DE**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY DE- NO BUSINESS LOCATION				
COLLEGE OR SCHOOL N.O.C.- ALL EMPLOYEES INCLUDING OFFICE	0965	29415.00	0.46	135

DE MANUAL PREMIUM $ 135

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	136
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	136
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	6
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	6
TOTAL PREMIUM	147
TOTAL ESTIMATED PREMIUM	147
DEPOSIT AMOUNT DUE	147

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-FL**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY FL- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	424452.00	0.37	1570

FL MANUAL PREMIUM $ 1570

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 22
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	1592
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
-1.60% PREMIUM DISCOUNT(0063)	-25
TERRORISM(9740)	42
TOTAL ESTIMATED PREMIUM	1609
TOTAL PREMIUM	1609
DEPOSIT AMOUNT DUE	1609

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-GA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY GA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	22997.00	0.69	159

GA MANUAL PREMIUM $ 159

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	161
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	161
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	4
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	9
TOTAL ESTIMATED PREMIUM	173
TOTAL PREMIUM	173
DEPOSIT AMOUNT DUE	173

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **12432-HI**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 DEPARTMENT OF LABOR IDENTIFIER 0007723415 WILKES UNIVERSITY 92 LIMUKELE ST # 5081 KAPOLEI , HI 96707 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.94	0

HI MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-IA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY IA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	13127.00	0.42	55

IA MANUAL PREMIUM $ 55

15.00% COMPANY DEVIATION DEBIT(9039)	$ 8
1.10% EMPL. LIAB. INCREASED LIMITS(9812)	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	64
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	64
-0.90% PREMIUM DISCOUNT(0063)	-1
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	1
TOTAL ESTIMATED PREMIUM	65
TOTAL PREMIUM	65
DEPOSIT AMOUNT DUE	65

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-ID**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 676 W PULLMAN RD MOSCOW , ID 83843 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	17017.00	0.52	88

ID MANUAL PREMIUM $ 88

15.00% COMPANY DEVIATION DEBIT(9039)	$	13
1.10% EMPL. LIAB. INCREASED LIMITS(9812)		1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		102
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		102
-1.60% PREMIUM DISCOUNT(0063)		-2
TERRORISM(9740)		2
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		2
TOTAL ESTIMATED PREMIUM		104
TOTAL PREMIUM		104
DEPOSIT AMOUNT DUE		104

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-IL**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **1827 N HIGHLAND AVE** **ARLINGTON HEIGHTS , IL 60004** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**31116.00**	**0.45**	**140**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **IL- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.45**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

IL MANUAL PREMIUM $ 140

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	142
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	142
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	146
1.092% IL WC COMM OP FUND SURCHARGE	2
TOTAL PREMIUM	148
DEPOSIT AMOUNT DUE	148

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE CHARTER OAK FIRE INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **15318-IN**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY IN- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	25647.00	0.50	128

IN MANUAL PREMIUM $ 128

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	129
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	129
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	131
1.009 SECOND INJURY FUND SURCHARGE(0935)	1
TOTAL PREMIUM	132
DEPOSIT AMOUNT DUE	132

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-KS**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 21038 NORTH SAILWAY OVERBROOK , KS 66524 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	100320.00	0.56	562

KS MANUAL PREMIUM $ 562

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$	6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		568
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		568
-0.90% PREMIUM DISCOUNT(0064)		-5
TERRORISM(9740)		3
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		6
TOTAL ESTIMATED PREMIUM		572
TOTAL PREMIUM		572
DEPOSIT AMOUNT DUE		572

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE STANDARD FIRE INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **15245-KY**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY KY- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	1215.00	0.28	3

KY MANUAL PREMIUM $ 3

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	3
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	3
-0.90% PREMIUM DISCOUNT(0064)	0
TERRORISM(9740)	0
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	0
TOTAL ESTIMATED PREMIUM	3
5.53% KY SPECIAL FUND ASSESSMENT	0
TOTAL PREMIUM	3
DEPOSIT AMOUNT DUE	3

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-LA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY LA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL (COUNTY/TOWN CODE 9999)	8868	12252.00	0.75	92

LA MANUAL PREMIUM $ 92

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$	1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		93
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM		NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		93
-0.90% PREMIUM DISCOUNT(0064)		-1
TERRORISM(9740)		0
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		1
TOTAL ESTIMATED PREMIUM		93
TOTAL PREMIUM		93
DEPOSIT AMOUNT DUE		93

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13439-MA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **7 FORSYTHIA LN** **WESTPORT , MA 02790** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**73903.00**	**0.56**	**414**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **45 STARLIGHT LN** **EASTHAM , MA 02642** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.56**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

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

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
71 HOWARD ST CAMBRIDGE , MA 02139 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.56	0
LOCATION 004				
FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
MA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.56	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

MA MANUAL PREMIUM $ 406

-2.00% COMPANY DEVIATION CREDIT(9037)	$ -8
2.00% EMPL. LIAB. INCREASED LIMITS(9812)	8
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	414
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	414
-1.60% PREMIUM DISCOUNT(0063)	-7
0% LOSS CONSTANT(0032)	20
EXPENSE CONSTANT(0900)	250
TERRORISM(9740)	22
TOTAL ESTIMATED PREMIUM	699
4.68% DIA ASSESSMENT	19
TOTAL PREMIUM	710
DEPOSIT AMOUNT DUE	718

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-MD**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **MD- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**36395.00**	**0.40**	**146**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **1205 SABINA AVE** **BALTIMORE , MD 21209** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.40**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

MD MANUAL PREMIUM $ 146

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 2
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	148
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	148
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	39
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	10
TOTAL ESTIMATED PREMIUM	196
TOTAL PREMIUM	196
DEPOSIT AMOUNT DUE	196

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS COMMERCIAL CASUALTY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **29815-ME**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 STATE UNEMPLOYMENT IDENTIFIER 0731311000 WILKES UNIVERSITY ME- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.46	0

ME MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
2.41% WC BOARD SURCHARGE	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11347-MI**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 7787 WINFIELD DR BRIGHTON , MI 48116 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	3160.00	0.41	13

MI MANUAL PREMIUM $ 13

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	13
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	13
-0.90% PREMIUM DISCOUNT(0064)	0
TERRORISM(9740)	1
TOTAL ESTIMATED PREMIUM	14
TOTAL PREMIUM	14
DEPOSIT AMOUNT DUE	14

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY COMPANY OF CONNECTICUT

INSURED'S NAME: WILKES UNIVERSITY **27405-MN**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **STATE UNEMPLOYMENT IDENTIFIER 000005008930** **WILKES UNIVERSITY** **29876 ISLE AVE** **NORTHFIELD , MN 55057** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**16354.00**	**0.78**	**128**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **STATE UNEMPLOYMENT IDENTIFIER 000005008930** **WILKES UNIVERSITY** **MN- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.78**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **STATE UNEMPLOYMENT IDENTIFIER 000005008930** **WILKES UNIVERSITY**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
138 MAPLE PARK DR MANKATO , MN 56001 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.78	0
LOCATION 004				
FEIN 240795506 ENTITY CD 001 00				
STATE UNEMPLOYMENT IDENTIFIER 000005008930 WILKES UNIVERSITY				
4914 RADAR RD HERMANTOWN , MN 55811 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.78	0

MN MANUAL PREMIUM $ 128

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	129
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	129
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	2
TOTAL ESTIMATED PREMIUM	130
1.54% SPECIAL FUND SURCHARGE	2
TOTAL PREMIUM	132
DEPOSIT AMOUNT DUE	132

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-MO**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **1478 S SUMMER PL** **SPRINGFIELD , MO 65809** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**11262.00**	**0.73**	**82**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **MO- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.73**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
808 E PACIFIC AVE WEBSTER GROVES , MO 63119 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.73	0

MO MANUAL PREMIUM $ 82

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	83
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	83
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	0
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	1
TOTAL ESTIMATED PREMIUM	83
3.00% MO SECOND INJURY FUND SURCHARGE	2
TOTAL PREMIUM	85
DEPOSIT AMOUNT DUE	85

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-MS**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY MS- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.52	0

MS MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13439-NC**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
NC- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	51898.00	0.52	270

NC MANUAL PREMIUM $ 270

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	273
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	273
-0.90% PREMIUM DISCOUNT(0064)	-2
TERRORISM(9740)	2
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	3
TOTAL ESTIMATED PREMIUM	276
TOTAL PREMIUM	276
DEPOSIT AMOUNT DUE	276

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-NH**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **36 CHRISTIAN FARM DR** **NEW BOSTON , NH 03070** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**34107.00**	**0.38**	**130**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **NH- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.38**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

NH MANUAL PREMIUM $ 130

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	131
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	131
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	133
TOTAL PREMIUM	133
DEPOSIT AMOUNT DUE	133

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-NJ**

RATE BUREAU ID: 000653087

EXP. MOD. EFFECTIVE DATE: 02-15-25

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **TAX IDENTIFIER NUMBER 240795506000** **WILKES UNIVERSITY** **7 WENDOVER RD** **MONTCLAIR , NJ 07042** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**198837.00**	**1.19**	**2366**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **TAX IDENTIFIER NUMBER 240795506000** **WILKES UNIVERSITY** **283 LENOX AVE** **YARDVILLE-GROVEVILLE , NJ 08620** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**1.19**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **TAX IDENTIFIER NUMBER 240795506000** **WILKES UNIVERSITY**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
NJ- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	1.19	0

NJ MANUAL PREMIUM $ 2366

1.40% EMPL. LIAB. INCREASED LIMITS(6199)	$	33
ADD FOR INCREASED LIMITS MINIMUM		28
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		2427
EXPERIENCE MODIFICATION:0.982 MODIFIED PREMIUM		2383
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		2383
TERRORISM(9740)		60
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)		20
TOTAL ESTIMATED PREMIUM		2463
3.58% SECOND INJURY FUND SURCHARGE		85
TOTAL PREMIUM		2548
DEPOSIT AMOUNT DUE		2548

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-NM**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY NM- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.58	0

NM MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION: MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11347-NV**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
NV- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.77	0
NV MANUAL PREMIUM $ 0				

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE PHOENIX INSURANCE COMPANY

INSURED'S NAME: WILKES UNIVERSITY **12610-NY**

RATE BUREAU ID: 001037884

EXP. MOD. EFFECTIVE DATE: 02-15-25

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **420 W 25TH ST** **NEW YORK , NY 10001** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**298715.00**	**0.50**	**1494**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **72 MEADS MOUNTAIN RD** **WOODSTOCK , NY 12498** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

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

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D) FEIN 240795506 ENTITY CD 001 00 (CONT'D) 434 W 120TH ST NEW YORK , NY 10027 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0
LOCATION 004 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 787 STATE ROUTE 79 WINDSOR , NY 13865 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0
LOCATION 005 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 31 NORTH DR RED HOOK , NY 12571 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0
LOCATION 006 FEIN 240795506 ENTITY CD 001 00				

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

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 (CONT'D) FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
WILKES UNIVERSITY 1851 ADAM CLAYTON POWELL JR BLVD NEW YORK , NY 10026 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0
LOCATION 007 FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY 524 E 83RD ST NEW YORK , NY 10028 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0
LOCATION 008 FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY 235 E 22ND ST NEW YORK , NY 10010 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.50	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 009 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **40 LINCOLN AVE** **BINGHAMTON , NY 13905** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**
LOCATION 010 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **115 CENTRAL PARK W** **NEW YORK , NY 10023** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**
LOCATION 011 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **3563 79TH ST** **JACKSON HEIGHTS , NY 11372** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 012 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **325 W 45TH ST** **NEW YORK , NY 10036** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**
LOCATION 013 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **NY- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.50**	**0**

NY MANUAL PREMIUM $ 1494

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD. $	**1494**
EXPERIENCE MODIFICATION:0.94 MODIFIED PREMIUM	**1404**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**1404**
-2.00% PREMIUM DISCOUNT(0063)	**-28**
TERRORISM(9740)	**128**
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	**12**
TOTAL ESTIMATED PREMIUM	**1516**
7.10% NY STATE ASSESSMENT	**110**
TOTAL PREMIUM	**1626**
DEPOSIT AMOUNT DUE	**1626**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **12432-OK**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY OK- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	29607.00	0.82	243

OK MANUAL PREMIUM $ 243

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	246
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	246
-0.90% PREMIUM DISCOUNT(0064)	-2
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	247
TOTAL PREMIUM	247
DEPOSIT AMOUNT DUE	247

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-OR**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 372 WHITE OAK CIR MEDFORD , OR 97504 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	2916.00	0.35	10

OR MANUAL PREMIUM $ 10

0.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	10
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	10
-1.60% PREMIUM DISCOUNT(0063)	0
TERRORISM(9740)	0
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	0
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
9.80% WC PREMIUM ASSESSMENT	1
TOTAL PREMIUM	11
DEPOSIT AMOUNT DUE	11

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-RI**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 EMPLOYER IDENTIFIER 0002309459 WILKES UNIVERSITY RI- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	22972.00	0.47	108

RI MANUAL PREMIUM $ 108

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	109
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	109
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	1
TOTAL ESTIMATED PREMIUM	110
TOTAL PREMIUM	110
DEPOSIT AMOUNT DUE	110

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-SC**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **SC- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**65576.00**	**0.43**	**282**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **113 MILES PARK DR** **COLUMBIA , SC 29223** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.43**	**0**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

SC MANUAL PREMIUM $ 282

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	285
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	285
-0.90% PREMIUM DISCOUNT(0064)	-3
TERRORISM(9740)	2
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	4
TOTAL ESTIMATED PREMIUM	288
TOTAL PREMIUM	288
DEPOSIT AMOUNT DUE	288

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS COMMERCIAL CASUALTY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **29815-TN**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY TN- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.27	0

TN MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION: MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY AND SURETY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **11223-TX**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **TX- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES	**8868**	**60447.00**	**0.37**	**224**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **729 SENDERO RD** **ARLINGTON , TX 76002** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES	**8868**	**IF ANY**	**0.37**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

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

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D) FEIN 240795506 ENTITY CD 001 00 (CONT'D) 13606 CANEY SPRINGS LN HOUSTON , TX 77044 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	IF ANY	0.37	0
LOCATION 004 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 6513 MIRANDA DR CORPUS CHRISTI , TX 78414 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	IF ANY	0.37	0
LOCATION 005 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY 1025 DARKWOOD DR FRISCO , TX 75035 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	IF ANY	0.37	0
LOCATION 006 FEIN 240795506 ENTITY CD 001 00				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
WILKES UNIVERSITY				
3105 CROWN ROCK DR EL PASO , TX 79938 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	IF ANY	0.37	0
LOCATION 007				
FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
14600 LONG SHADOW AVE EL PASO , TX 79938 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES	8868	IF ANY	0.37	0

TX MANUAL PREMIUM $ 224

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	227
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	227
-5.60% PREMIUM DISCOUNT(0063)	-13
TERRORISM(9740)	8
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	6
TOTAL ESTIMATED PREMIUM	228
TOTAL PREMIUM	228
DEPOSIT AMOUNT DUE	228

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS CASUALTY COMPANY OF CONNECTICUT

INSURED'S NAME: WILKES UNIVERSITY **27405-VA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **900 TIMBER CREEK PL** **VIRGINIA BEACH , VA 23464** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**80831.00**	**0.41**	**331**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **7018 WILD FLOWER LN** **FRANKTOWN , VA 23354** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.41**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

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

POLICY NUMBER: UB-1T152983-25-14-G

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
204 OAKENGATE TURN VIRGINIA BEACH , VA 23462 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.41	0
LOCATION 004				
FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
2045 CHADDS FORD DR RESTON , VA 20191 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.41	0
LOCATION 005				
FEIN 240795506 ENTITY CD 001 00				
WILKES UNIVERSITY				
314 VICTORIA WAY RICHMOND , VA 23238 NAICS: 611310				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.41	0
LOCATION 006				
FEIN 240795506 ENTITY CD 001 00				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 006 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
WILKES UNIVERSITY				
VA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.41	0

VA MANUAL PREMIUM $ 331

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 4
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	335
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	335
-0.90% PREMIUM DISCOUNT(0064)	-3
TERRORISM(9740)	8
TOTAL ESTIMATED PREMIUM	340
TOTAL PREMIUM	340
DEPOSIT AMOUNT DUE	340

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS COMMERCIAL CASUALTY COMPANY

INSURED'S NAME: WILKES UNIVERSITY **29815-VT**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY VT- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.78	0

VT MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$ 0
EXPERIENCE MODIFICATION: MODIFIED PREMIUM	0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	0
-0.90% PREMIUM DISCOUNT(0064)	0
TOTAL ESTIMATED PREMIUM	0
1.50% ADMINISTRATIVE FUND ASSESSMENT SURCHRG	0
TOTAL PREMIUM	0
DEPOSIT AMOUNT DUE	0

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-WA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 240795506 ENTITY CD 001 00 WILKES UNIVERSITY WA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	2916.00	0.022	1

WA MANUAL PREMIUM $ 1

ADD FOR STOP GAP MINIMUM	$ 149
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	150
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	150
TOTAL ESTIMATED PREMIUM	150
TOTAL PREMIUM	150
DEPOSIT AMOUNT DUE	150

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13579-WI**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **4522 COUNTY ROAD Q** **DODGEVILLE , WI 53533** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**7739.00**	**0.38**	**29**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **WI- NO BUSINESS LOCATION**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.38**	**0**

DATE OF ISSUE: **01-08-25 RS** SCHEDULE NO: **1** OF **2**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

WI MANUAL PREMIUM $ 29

1.10% EMPL. LIAB. INCREASED LIMITS(9812)	$ 0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	29
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	29
-1.60% PREMIUM DISCOUNT(0063)	0
TERRORISM(9740)	2
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	1
TOTAL ESTIMATED PREMIUM	32
TOTAL PREMIUM	32
DEPOSIT AMOUNT DUE	32

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

INSURED'S NAME: WILKES UNIVERSITY **13439-WV**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **337 S HIGH ST** **MORGANTOWN , WV 26501** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**28199.00**	**0.25**	**70**
LOCATION 002 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY** **105 MYRTLE DR** **GERRARDSTOWN , WV 25420** **NAICS: 611310**				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**IF ANY**	**0.25**	**0**
LOCATION 003 **FEIN 240795506 ENTITY CD 001 00** **WILKES UNIVERSITY**				

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: **UB-1T152983-25-14-G**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 003 (CONT'D)				
FEIN 240795506 ENTITY CD 001 00 (CONT'D)				
WV- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.25	0

WV MANUAL PREMIUM $ 70

1.40% EMPL. LIAB. INCREASED LIMITS(9812)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	71
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	71
-0.90% PREMIUM DISCOUNT(0064)	-1
TERRORISM(9740)	1
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	2
TOTAL ESTIMATED PREMIUM	73
5.00% REGULATORY SURCHARGE	4
0.55% FIRE AND CASUALTY SURCHARGE	0
TOTAL PREMIUM	77
DEPOSIT AMOUNT DUE	77

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 54 03 01 00 - 001	ALASKA LIMIT OF LIABILITY ENDT
WC 09 06 07 A - 001	FL WC INS GUARANTY ASSOC SURCH NOTIFIC
WC 24 04 06 D - 001	MISSOURI EMPLOYER PAID MEDICAL ENDT
WC 36 03 06 00 - 001	OREGON LIMITS OF LIABILITY
WC 36 06 02 OO - 001	OREGON CONFIDENTIALITY ENDORSEMENT
WC 36 06 04 00 - 001	OREGON AMENDATORY ENDORSEMENT
WC 00 03 03 C - 001	EMPLOYERS LIAB COVERAGE ENDT
WC 00 04 04 00 - 001	PENDING RATE CHANGE ENDORSEMENT
WC 00 04 06 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 06 A - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 14 00 - 001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC 00 04 14 A - 001	NOTIFICATION OF CHG IN OWNR ENDT
WC 00 04 22 C - 001	TERRORISM RISK INS PROG REAUTH ACT ENDT
WC 00 04 24 O0 - 001	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC 00 04 25 00 - 001	EXPER RATING MOD FACTOR REVISION ENDT
WC 04 03 01 B - 001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 09 04 03 C - 001	FL TRIPRA ENDORSEMENT
WC 28 04 05 00 - 001	NH AUDIT NONCOMPLIANCE CHARGE ENDT
WC 32 03 01 D - 001	NORTH CAROLINA AMENDED COVERAGE ENDT
WC 35 03 03 00 - 001	OK EMP LIAB INTENTIONAL TORT EXCL ENDT
WC 99 03 99 00 - 001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
WC 99 03 A1 00 - 001	NOTICE OF CANCELATION
WC 99 03 C3 00 - 001	SPECIAL PROVISIONS ENDT
WC 99 03 F3 00 - 001	CA LIMITS OF LIABILITY ENDT
WC 99 04 28 00 - 001	PREMIUM MANUALS AND DUE DATE ENDORSEMENT
WC 99 06 36 B - 001	CANCELLATION AMENDMENT - WASHINGTON
WC 99 06 F4 00 - 001	MANAGED CARE PROGRAM ENDORSEMENT
WC 99 06 K2 A - 001	WEST VIRGINIA EMPLOYERS LIABILITY ENDST
WC 00 04 21 E - 001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC 00 04 21 F - 001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT
WC 99 04 08 00 - 001	PREMIUM DISCOUNT ENDORSEMENT
WC 99 04 10 00 - 001	PREMIUM ADJ. FROM EFFECTIVE DATE ENDT.
WC 99 01 19 C - 001	TRIPRA DISCLOSURE ENDORSEMENT
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 09 04 09 00 - 001	FLORIDA PREMIUM DUE DATE ENDORSEMENT
WC 02 04 01 C - 001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
WC 02 06 01 C - 001	AZ CANCELLATION AND NONRENEWAL ENDT
WC 02 06 03 A - 001	AZ AMENDATORY ENDORSEMENT
WC 04 03 17 B - 001	EMPLOYEE INSD BY GENERL EMPLYER EXCLUDED
WC 04 03 45 A - 001	COMPREHENSIVE PERSONAL LIAB POL EXCL
WC 04 03 60 B - 001	EMPLOYERS' LIAB COV AMENDATORY ENDT-CA
WC 04 04 21 00 - 001	OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
WC 04 04 22 00 - 001	CALIFORNIA SHORT-RATE CANCELATION ENDT
WC 04 06 01 B - 001	CA CANCELATION ENDT
WC 05 04 02 00 - 001	COLORADO CLASSIFICATION ENDORSEMENT
WC 06 03 01 00 - 001	CT APPLICATION OF WORKERS COMPENSATION
WC 06 03 03 C - 001	CONNECTICUT WC FUNDS ENDORSEMENT
WC 06 06 01 A - 001	CT NONRENEWAL AND RENEWAL ENDT
WC 07 04 08 00 - 001	DE MERIT RATING PLAN ENDORSEMENT
WC 07 06 01 00 - 001	DELAWARE NONRENEWAL ENDORSEMENT
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 04 07 A - 001	FL NON-COOPERATION WITH PREM AUDIT ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.
WC 09 06 09 A - 001	FLORIDA CANCELLATION AND NONRENEWAL ENDT
WC 10 06 01 C - 001	GA CANC NONRENEWAL AND CHANGE ENDT
WC 12 06 01 F - 001	IL AMENDATORY ENDT
WC 12 06 03 00 - 001	ILLINOIS RENEWAL ENDORSEMENT
WC 15 04 01 A - 001	KANSAS FINAL PREMIUM ENDORSEMENT
WC 15 06 01 A - 001	KANSAS CANCELATION AND NONRENEWAL ENDT.
WC 16 03 05 00 - 001	KY PART ONE WC INSURANCE ENDORSEMENT
WC 16 06 01 00 - 001	KY CANCELATION AND NONRENEWAL ENDT.
WC 16 06 02 00 - 001	KY NOTICE OF APPEAL RIGHTS ENDORSEMENT

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC 17 06 01 J - 001	LOUISIANA AMENDATORY ENDORSEMENT
WC 17 06 02 A - 001	LA COST CONTAINMENT ACT ENDORSEMENT
WC 18 06 01 00 - 001	MAINE INSPECTION IMMUNITY ENDORSEMENT
WC 18 06 03 A - 001	MAINE CANCELATION AND NONRENEWAL ENDT
WC 18 06 04 00 - 001	ME FINAL PREM AUDIT ENDT
WC 18 06 06 00 - 001	ME NOTICE OF FILING FIRST RPT OF INJURY
WC 18 06 07 A - 001	MAINE EMPLOYMENT REHABILITATION FUND END
WC 19 06 01 G - 001	MD CANCELLATION AND NONRENEWAL ENDT
WC 20 03 01 00 - 001	MA LIMITS OF LIABILITY ENDORSEMENT
WC 20 03 02 A - 001	MASSACHUSETTS - ASSESMENT CHARGE
WC 20 03 03 D - 001	MA NOTICE TO POLICYHOLDER ENDORSEMENT
WC 20 04 05 00 - 001	MASSACHUSETTS PREMIUM DUE DATE ENDT
WC 20 06 01 A - 001	MA CANCELLATION ENDORSEMENT
WC 21 03 03 A - 001	MICHIGAN NOTICE TO POLICYHOLDERS
WC 21 03 04 00 - 001	MICHIGAN LAW ENDORSEMENT
WC 22 00 00 A - 001	MN AMENDATORY ENDT
WC 22 03 01 00 - 001	MN COMPLIANCE WITH APPLICABLE TRADE LAW
WC 22 06 01 D - 001	MINNESOTA CANC AND NON RENEWAL ENDT
WC 23 06 01 00 - 001	MS CANC NONRENEWAL AND RENEWAL ENDT
WC 24 03 02 00 - 001	MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT
WC 24 06 01 B - 001	MO CANCELATION AND NON-RENEWAL ENDT.
WC 24 06 02 B - 001	MO PROPERTY & CASUALTY GUARANTY ASSOC.
WC 24 06 04 C - 001	MISSOURI AMENDATORY ENDORSEMENT
WC 27 06 01 C - 001	NV CANCELLATION AND NON RENEWAL ENDT
WC 28 06 01 00 - 001	NH SOLE REPRESENTATIVE END'T
WC 28 06 04 00 - 001	NH AMENDATORY ENDT
WC 29 03 06 B - 001	NJ PART TWO EMPLOYERS LIABILITY ENDT.
WC 30 03 01 00 - 001	NM SAFETY DEVICE COVERAGE ENDORSEMENT
WC 30 04 01 A - 001	NM WC PREM ADJ PROGRAM
WC 30 06 01 A - 001	NM CANCELLATION AND NONRENEWAL END
WC 31 03 08 00 - 001	NEW YORK LIMIT OF LIABILITY ENDORSEMENT
WC 31 03 19 N - 001	NY CONST CLASS PREM ADJUST PROG
WC 31 04 05 A - 001	NY SAFE PTNT HNDLG ACT PRGM ENDT FLAT CR

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 00 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

LISTING OF ENDORSEMENTS EXTENSION OF INFO PAGE

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

WC 31 06 18 A - 001	NEW YORK NOTICE OF RIGHT TO APPEAL
WC 35 06 01 F - 001	OK CAN, NONRENEWAL AND CHANGE ENDT
WC 35 06 03 00 - 001	OK FRAUD WARNING ENDT
WC 36 06 01 E - 001	OR CANCELLATION ENDORSEMENT
WC 38 04 01 B - 001	RI SHORT RATE CANCELLATION ENDORSEMENT
WC 38 06 01 00 - 001	RHODE ISLAND DIRECT LIABILITY STATUTE
WC 38 06 02 00 - 001	RI SAFETY INSPECTION ENDT
WC 39 06 01 00 - 001	SC CANCELLATION AND NONRENEWAL ENDT
WC 42 03 01 L - 001	TEXAS AMENDATORY ENDORSEMENT
WC 44 06 01 00 - 001	VERMONT LAW ENDORSEMENT
WC 44 06 02 C - 001	VT CANCELLATION AND NONRENEWAL ENDT
WC 45 06 02 00 - 001	VA AMENDATORY ENDT
WC 47 06 01 00 - 001	WEST VIRGINIA CANCELLATION ENDORSEMENT
WC 48 06 01 C - 001	WISCONSIN LAW ENDORSEMENT
WC 48 06 06 B - 001	WISCONSIN CANCELLATION AND NON RENEWAL
WC 52 06 02 15 - 001	HAWAII NOTIFICATION ENDORSEMENT
WC 54 06 01 A - 001	AK NOTICE OF INSTALLMENT OPTION ENDT
WC 54 06 02 00 - 001	ALASKA CANCELATION AND NONRENEWAL ENDT
WC 99 06 46 00 - 001	ILLINOIS AMENDATORY ENDORSEMENT
WC 99 06 P5 00 - 001	WC AND EMPL LIAB INFO PAGE-OK AMEND ENDT
WC 99 06 T1 00 - 001	NY NOTICE CANCEL DESIGNATED GOV ENTITY
WC 17 03 03 00 - 001	LOUISIANA DUTY TO DEFEND

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. The Policy

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

B. Who is Insured

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

C. Workers Compensation Law

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

D. State

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

E. Locations

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

PART ONE
WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

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

E. Other Insurance

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

F. Payments You Must Make

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

1. of your serious and willful misconduct;

2. you knowingly employ an employee in violation of law;

3. you fail to comply with a health or safety law or regulation; or

4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

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

G. Recovery From Others

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

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.

2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.

3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.

4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.

5. This insurance conforms to the parts of the workers compensation law that apply to:

a. benefits payable by this insurance;

b. special taxes, payments into security or other special funds, and assessments payable by us under that law.

6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

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

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

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

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

2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.

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

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

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

B. We Will Pay

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

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

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

2. For care and loss of services; and

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

4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;

2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;

3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;

4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;

5. Bodily injury intentionally caused or aggravated by you;

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

7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;

8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C Sections 1331 et seq.), the Defense Base Act (42 U.S.C Sections 1651–1654), the Federal Mine Safety and Health Act (30 U.S.C Sections 801 et seq. and 901–944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;

10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;

11. Fines or penalties imposed for violation of federal or state law; and

12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

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

have the right to investigate and settle these claims, proceedings and suits.

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

E. We Will Also Pay

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

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

2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;

3. Litigation costs taxed against you;

4. Interest on a judgment as required by law until we offer the amount due under this insurance; and

5. Expenses we incur.

F. Other Insurance

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

G. Limits of Liability

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

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

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

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

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

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

H. Recovery From Others

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

I. Actions Against Us

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

1. You have complied with all the terms of this policy; and

2. The amount you owe has been determined with our consent or by actual trial and final judgment.

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

PART THREE
OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.

2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.

3. We will reimburse you for the benefits required by the workers compensation law of that state if we are not permitted to pay the benefits directly to persons entitled to them.

4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

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

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.
4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE
PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

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

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

D. Premium Payments

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

E. Final Premium

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

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

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

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

F. Records

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

G. Audit

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

PART SIX
CONDITIONS

A. Inspection

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancelation

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

2. We may cancel this policy. We must mail or deliver to you not less than ten days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

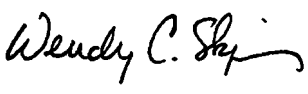
3. The policy period will end on the day and hour stated in the cancelation notice.

4. Any of these provisions that conflict with a law that controls the cancelation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

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

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



Secretary

President

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 54 03 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

ALASKA LIMIT OF LIABILITY ENDORSEMENT

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

THIS POLICY LIMITS COVERAGE FOR ATTORNEY FEES UNDER RULE 82 OF THE ALASKA RULES OF CIVIL PROCEDURE

In any suit in Alaska in which we have a right or duty to defend an insured in addition to the limits of liability, our obligation under the applicable coverage to pay attorney fees taxable as costs against the insured is limited as follows:

Rule 82 of the Alaska Rules of Civil Procedure provides that if you are held liable, some or all of the attorney fees of the person making a claim against you must be paid by you. The amount that must be paid by you is determined by Rule 82. We provide coverage for attorney fees for which you are liable under Rule 82 subject to the following limitation:

> We will not pay that portion of any attorney fees that are in excess of fees calculated by applying the schedule in Rule 82(b)(1) for contested cases to the limit of liability of the applicable coverage.

This limitation means the potential costs that may be awarded against you as attorney fees may not be covered in full. You will have to pay any attorney fees not covered directly. For example, the attorney fees provided by the schedule in Civil Rule 82(b)(1) for contested cases are:

> 20% of the first $25,000 of a judgment or claim settlement.
> 10% of the amounts over $25,000 of a judgment or claim settlement.

If a court awards a judgment against you in the amount of $125,000, in addition to that amount you would be liable under Rule 82(b)(1) for attorney fees of $15,000 calculated as follows:

	20% of $ 25,000		$ 5,000
	10% of $100,000		$10,000
Total Award	$125,000	Total Attorney Fees	$15,000

If the limit of liability of the applicable coverage is $100,000, we would pay $100,000 of the $125,000 award, and $12,500 Rule 82(b)(1) Attorney Fees, calculated as follows:

	20% of $25,000		$ 5,000
	10% of $75,000		$ 7,500
Total Limit of Liability	$100,000	Total Attorney Fees Covered	$12,500

You would be liable to pay, directly and without assistance, the remaining $25,000 in liability, plus the remaining $2,500 in attorney fees not covered by this policy.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 06 07 (A)

POLICY NUMBER: UB-1T152983-25-14-G

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

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

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

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

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

F. **Florida Workers' Compensation Insurance Guaranty Association Surcharge**

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

Schedule

Surcharge rate 0.00 %

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 04 06 (D)

POLICY NUMBER: UB-1T152983-25-14-G

MISSOURI EMPLOYER PAID MEDICAL ENDORSEMENT

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

As a Missouri employer, you have the right, as provided by Section 287.957 of the Revised Statutes of Missouri, to have medical-only claims that do not exceed 20% of the current primary and excess loss split point amount, as shown in the Schedule below, excluded from your experience rating modification calculation. This will only be allowed when you pay all of the employee's medical costs; there is no lost time from the employment, other than the first three days or less of disability; and no claim is filed. The current primary and excess loss split point amount is provided in the rating values of NCCI's ***Experience Rating Plan Manual*****. You still must report all injuries, regardless of the dollar amount, to the Division of Workers' Compensation and to us.**

However, it should be noted that if, at any time, the medical expenses that are paid out-of-pocket due to a particular injury ever exceed 20% of the current primary and excess loss split point amount and/or the employee misses more than three days from work due to the injury, then this injury must be reported to us as a claim. We will pay the full amount of the claim, which includes any reimbursements due to you for past medical expenses incurred by you for this particular claim. As a result, the total amount of losses incurred by us due to this claim will be included in your experience modification calculation.

Schedule

20% of the Current Primary and Excess Loss Split Point Amount 4,200

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 03 06 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

OREGON LIMITS OF LIABILITY ENDORSEMENT

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

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

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 36 06 02 (OO)

POLICY NUMBER: UB-1T152983-25-14-G

OREGON CONFIDENTIALITY ENDORSEMENT

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

1. You agree to hold all information provided by us in trust and confidence.

2. You and your employees must not disclose confidential information about an injured worker to anyone except us unless required to do so by law or with written consent of the injured worker. You will take steps necessary to protect the confidentiality of information about injured workers, including obtaining specific contractual promises from your employees and agents not to disclose any confidential information except as provided in this endorsement. You must not use confidential information for purposes other than those necessary to directly further the purposes of this endorsement.

3. You must not use confidential information in such a manner that is likely to allow other persons to know the name or identity of an injured worker, or allow other persons to know any other particulars of a worker's injury claim, except for those matters over which you as an employer have the ability and the right to direct and control. In no case can you use confidential information either singly or in concert to discriminate unlawfully against any injured worker.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 04 (00)

POLICY NUMBER: UB-1T152983-25-14-G

OREGON AMENDATORY ENDORSEMENT

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

Part Two—Employers Liability Insurance, Section C. (Exclusions), Item 5. of the policy is replaced by the following:

5. Any bodily injury intentionally caused or aggravated by you, or that is the result of your engaging in conduct equivalent to an intentional tort, however defined, including as described by ORS 656.156, or other tortious conduct, or conduct or activity as described by ORS 656.018(3), such that you lose your immunity from civil liability under the workers compensation laws of Oregon;

Part Two—Employers Liability Insurance, Section C. (Exclusions) of the policy is revised by adding the following:

13. Any cause of action or remedy arising out of or under ORS 656.019 or ORS 654.305 through ORS 654.336.

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

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

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

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 03 03 (C)

POLICY NUMBER: UB-1T152983-25-14-G

EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

A. Part One (Workers Compensation Insurance) does not apply to work in a state shown in the Schedule.

B. Part Two (Employers Liability Insurance) applies to work in states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.

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

This insurance does not cover:

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

SCHEDULE

States

WA

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 04 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

PENDING RATE CHANGE ENDORSEMENT

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

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

SCHEDULE

STATE

MD

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 06 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

PREMIUM DISCOUNT ENDORSEMENT

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

SCHEDULE

1. STATE

ESTIMATED ELIGIBLE PREMIUM

First $5,000	Next $95,000	Next $400,000	Balance

2. AVERAGE PERCENTAGE DISCOUNT: See Information Page Schedule(s)

3. OTHER POLICIES:

4. IF THERE ARE NO ENTRIES IN ITEMS 1, 2, AND 3 OF THE SCHEDULE SEE THE PREMIUM DISCOUNT ENDORSEMENT ATTACHED TO YOUR POLICY NUMBER:

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 06 (A)

POLICY NUMBER: UB-1T152983-25-14-G

PREMIUM DISCOUNT ENDORSEMENT

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

SCHEDULE

1. State **Estimated Eligible Premium**

First	Next	Next	Balance
$10,000	$190,000	$1,550,000	

2. Average percentage discount: See Information Page Schedule(s)

3. Other policies:

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 14 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 14 (A)

POLICY NUMBER: UB-1T152983-25-14-G

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

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

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

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

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

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

Endorsement Effective | Policy No. | EndorsementNo.

Insured | Premium

Insurance Company | Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 22 (C)

POLICY NUMBER: UB-1T152983-25-14-G

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. 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 2019

"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, 2021, and ending on December 31, 2027 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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 22 (C)

POLICY NUMBER: UB-1T152983-25-14-G

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed $200,000,000, 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

For all other states please refer to the other Federal Terrorism Risk Insurance Act Disclosure Endorsements attached to your policy

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 24 (O0)

POLICY NUMBER: UB-1T152983-25-14-G

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

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

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

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

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

Note:

For coverage under state – approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

Schedule

State(s)	**Basis of Audit Noncompliance Charge**	**Maximum Audit Noncompliance Charge Multiplier**
All states, except AK, CA, FL, IN, LA, MA, MO, MT, ND, NH, NY, OH, PA, TX, WA, WI, WY	Estimated annual premium	Multiplier varies based on number of consecutive policy periods in which you failed to comply with the Audit provision - First policy period: 25% - Second consecutive policy period: 50% - Third (or more) consecutive policy period(s): 75%

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 00 04 25 (00)

POLICY NUMBER: UB-1T152983-25-14-G

EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT

This endorsement is added to Part Five—Premium of the policy.

The premium for the policy is adjusted by an experience rating modification factor. The factor shown on the Information Page may be revised and applied to the policy in accordance with our manuals and endorsements. We will issue an endorsement to show the revised factor, if different from the factor shown, when it is calculated.

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

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

Endorsement Effective Policy No. Endorsement No

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 01 (B)

POLICY NUMBER: UB-1T152983-25-14-G

POLICY AMENDATORY ENDORSEMENT – CALIFORNIA

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

1. **Minors Illegally Employed – Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.
2. **Punitive or Exemplary Damages – Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.
3. **Increase in Indemnity Payment – Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars ($100).

   If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.
4. **Application of Policy.** Part One, "Workers Compensation Insurance", A, "How This Insurance Applies", is amended to read as follows:

   This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.
6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.
7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.
8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:

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

the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

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

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

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

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

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured	Insurance Company	

Countersigned by _____

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2019.

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 2019.
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, 2021, and ending on December 31, 2027, 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 occurring in any calendar year exceed $200,000,000, 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 Insured Losses that exceed $100,000,000,000.

3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

$ 0.01 per $100 of Remuneration

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

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

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 28 04 05 (00)

POLICY NUMBER: UB-1T152983-25-14-G

NEW HAMPSHIRE AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

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

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

In accordance with NH ST 412:35, 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 will apply an Audit Noncompliance Charge equal to three times the estimated annual premium and set the estimated premium as the final premium.

Upon receipt of notification of the ANC penalty charge and final premium, you will have an additional 10 days to request that the ANC penalty charge be waived and the final premium be recalculated based on actual exposure by completing the audit. We will not deny a timely request by you for a waiver and recalculation. Your request will be granted upon completion of the audit.

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

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

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 32 03 01 (D)

POLICY NUMBER: UB-1T152983-25-14-G

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

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

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

D. Cancellation and Nonrenewal

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

2. We may cancel this policy.

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

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

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

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

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

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

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

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

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

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

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

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

(c) If we cancel for any of the reasons listed in paragraph (b), we must provide you with at least 15 days prior written notice of cancellation stating the precise reason for cancellation. We may provide this notice by registered or certified mail, return receipt requested, to you and any other person designated in the policy to receive notice of cancellation at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Whenever notice of cancellation is given by registered or certified mail, cancellation will not be effective unless and until that method is employed and completed. Notice of intent to cancel given by registered or certified mail shall be conclusively presumed completed three days after the notice is sent if, on the same day that notice is sent by registered or certified mail, the insurer also

provides notice by first-class mail and by electronic means if available as defined in G.S. 58-2-255(a) to the insured and any other person designated in the policy to receive notice. Any such supplemental notice given by electronic means shall be effective for the limited purpose of establishing this conclusive presumption. Notice of cancellation may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send notice as provided in this paragraph to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

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

3. We may refuse to renew this policy:

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

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

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

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by_____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 35 03 03 (00)

POLICY NUMBER: UB-1T152983-25-14-G

OKLAHOMA EMPLOYERS LIABILITY INTENTIONAL TORT EXCLUSION ENDORSEMENT

Part Two – Employers Liability Insurance, C – Exclusions, 5. is replaced by the following:

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury that you knew or should have known was substantially certain to occur from an act caused, committed, or aggravated by you;

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

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

Endorsement Effective | Policy No. | Endorsement No.

Insured | Premium

Insurance Company | Countersigned By _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 99 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

CALIFORNIA WORKERS' COMPENSATION NOTICE OF NON-RENEWAL

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

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

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

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

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

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

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

6. We made a written offer to you at least 30 days, but not more than 120 days, prior to the end of the policy period to renew the policy at a changed premium rate.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 A1 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF CANCELATION

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 C3 (00) –

POLICY NUMBER: UB-1T152983-25-14-G

SPECIAL PROVISIONS ENDORSEMENT STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 00 03 03 (C)-001	EMPLOYERS LIAB COVERAGE ENDT
APPLIES TO STATE(S):	AK AL AZ CO CT DE GA HI IA ID IL IN KS KY LA MD ME MN MO MS NC NH NM NV NY OK OR RI SC TN TX VA VT WA WI
WC 00 04 04 (00)-001	PENDING RATE CHANGE ENDORSEMENT
APPLIES TO STATE(S):	AK AL AZ CO CT DE FL GA HI IA ID IN KY LA MD ME MS NC NJ NV NY OK OR RI SC VA VT WI WV
WC 00 04 06 (A)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	MN NJ TN
WC 00 04 06 (00)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	AL CT DE GA IA KS KY MO NC NV SC TX VA VT
WC 00 04 14 (A)-001	NOTIFICATION OF CHG IN OWNR ENDT
APPLIES TO STATE(S):	AK AL AZ CO CT DE FL GA HI IA ID IL IN KS KY LA MD ME MI MN MO MS NH NM NV NY OK OR RI SC TN TX VA WI WV
WC 00 04 14 (00)-001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
APPLIES TO STATE(S):	MA VT
WC 00 04 19 (00)-001	PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S):	CT DE ID IN MN NC NJ NY WI
WC 00 04 21 (E)-001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT
APPLIES TO STATE(S):	DE NJ NY
WC 00 04 21 (F)-001	CATASTROPHE (O/T CERT ACTS OF TERR) ENDT
APPLIES TO STATE(S):	AK AL AZ CA CO CT GA HI IA ID IL IN KS KY LA MD ME MS NC NH NV OK OR RI SC TN VT WI WV
WC 00 04 22 (C)-001	TERRORISM RISK INS PROG REAUTH ACT ENDT
APPLIES TO STATE(S):	AK AL AZ CA CO CT DE GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS NC NH NJ NM NV NY OK OR RI SC TN TX VA VT WI WV
WC 00 04 24 (O0)-001	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
APPLIES TO STATE(S):	AL AZ CO CT DE GA HI IA ID IL IN KS KY MD ME MI MS NC NM NV OK OR RI SC TN VA VT WA WV
WC 00 04 25 (00)-001	EXPER RATING MOD FACTOR REVISION ENDT
APPLIES TO STATE(S):	AK AL AZ CO CT DE GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS NC NH NJ NM NV NY OK OR RI SC TN TX VA VT WI WV
WC 02 04 01 (C)-001	AZ ALCOHOL & DRUG FREE WK PLACE PREM END
APPLIES TO STATE(S):	AZ
WC 02 06 01 (C)-001	AZ CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):	AZ
WC 02 06 03 (A)-001	AZ AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	AZ
WC 04 03 01 (B)-001	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
APPLIES TO STATE(S):	CA

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

POLICY NUMBER: UB-1T152983-25-14-G

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 04 03 17 (B)-001 EMPLOYEE INSD BY GENERL EMPLYER EXCLUDED
APPLIES TO STATE(S): CA
WC 04 03 45 (A)-001 COMPREHENSIVE PERSONAL LIAB POL EXCL
APPLIES TO STATE(S): CA
WC 04 03 60 (B)-001 EMPLOYERS' LIAB COV AMENDATORY ENDT-CA
APPLIES TO STATE(S): CA
WC 04 04 21 (00)-001 OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
APPLIES TO STATE(S): CA
WC 04 04 22 (00)-001 CALIFORNIA SHORT-RATE CANCELATION ENDT
APPLIES TO STATE(S): CA
WC 04 06 01 (B)-001 CA CANCELATION ENDT
APPLIES TO STATE(S): CA
WC 05 04 02 (00)-001 COLORADO CLASSIFICATION ENDORSEMENT
APPLIES TO STATE(S): CO
WC 06 03 01 (00)-001 CT APPLICATION OF WORKERS COMPENSATION
APPLIES TO STATE(S): CT
WC 06 03 03 (C)-001 CONNECTICUT WC FUNDS ENDORSEMENT
APPLIES TO STATE(S): CT
WC 06 06 01 (A)-001 CT NONRENEWAL AND RENEWAL ENDT
APPLIES TO STATE(S): CT
WC 07 04 08 (00)-001 DE MERIT RATING PLAN ENDORSEMENT
APPLIES TO STATE(S): DE
WC 07 06 01 (00)-001 DELAWARE NONRENEWAL ENDORSEMENT
APPLIES TO STATE(S): DE
WC 09 03 03 (00)-001 FL EMPLRS LIAB COVERAGE ENDT
APPLIES TO STATE(S): FL
WC 09 04 03 (C)-001 FL TRIPRA ENDORSEMENT
APPLIES TO STATE(S): FL
WC 09 04 07 (A)-001 FL NON-COOPERATION WITH PREM AUDIT ENDT
APPLIES TO STATE(S):
WC 09 04 09 (00)-001 FLORIDA PREMIUM DUE DATE ENDORSEMENT
APPLIES TO STATE(S): FL
WC 09 06 06 (00)-001 FL EMPLOYMENT AND WAGE INFORMATION REL.
APPLIES TO STATE(S): FL
WC 09 06 07 (A)-001 FL WC INS GUARANTY ASSOC SURCH NOTIFIC
APPLIES TO STATE(S): FL
WC 09 06 09 (A)-001 FLORIDA CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):
WC 10 06 01 (C)-001 GA CANC NONRENEWAL AND CHANGE ENDT
APPLIES TO STATE(S): GA
WC 12 06 01 (F)-001 IL AMENDATORY ENDT
APPLIES TO STATE(S): IL
WC 12 06 03 (00)-001 ILLINOIS RENEWAL ENDORSEMENT
APPLIES TO STATE(S): IL
WC 15 04 01 (A)-001 KANSAS FINAL PREMIUM ENDORSEMENT
APPLIES TO STATE(S): KS
WC 15 06 01 (A)-001 KANSAS CANCELATION AND NONRENEWAL ENDT.

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S): KS
WC 16 03 05 (00)-001 KY PART ONE WC INSURANCE ENDORSEMENT
APPLIES TO STATE(S): KY
WC 16 06 01 (00)-001 KY CANCELATION AND NONRENEWAL ENDT.
APPLIES TO STATE(S): KY
WC 16 06 02 (00)-001 KY NOTICE OF APPEAL RIGHTS ENDORSEMENT
APPLIES TO STATE(S): KY
WC 17 03 03 (00)-001 LOUISIANA DUTY TO DEFEND
APPLIES TO STATE(S): LA
WC 17 06 01 (J)-001 LOUISIANA AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): LA
WC 17 06 02 (A)-001 LA COST CONTAINMENT ACT ENDORSEMENT
APPLIES TO STATE(S): LA
WC 18 06 01 (00)-001 MAINE INSPECTION IMMUNITY ENDORSEMENT
APPLIES TO STATE(S): ME
WC 18 06 03 (A)-001 MAINE CANCELATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): ME
WC 18 06 04 (00)-001 ME FINAL PREM AUDIT ENDT
APPLIES TO STATE(S): ME
WC 18 06 06 (00)-001 ME NOTICE OF FILING FIRST RPT OF INJURY
APPLIES TO STATE(S): ME
WC 18 06 07 (A)-001 MAINE EMPLOYMENT REHABILITATION FUND END
APPLIES TO STATE(S): ME
WC 19 06 01 (G)-001 MD CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S): MD
WC 20 03 01 (00)-001 MA LIMITS OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 03 02 (A)-001 MASSACHUSETTS - ASSESMENT CHARGE
APPLIES TO STATE(S): MA
WC 20 03 03 (D)-001 MA NOTICE TO POLICYHOLDER ENDORSEMENT
APPLIES TO STATE(S): MA
WC 20 04 05 (00)-001 MASSACHUSETTS PREMIUM DUE DATE ENDT
APPLIES TO STATE(S): MA
WC 20 06 01 (A)-001 MA CANCELLATION ENDORSEMENT
APPLIES TO STATE(S): MA
WC 21 03 03 (A)-001 MICHIGAN NOTICE TO POLICYHOLDERS
APPLIES TO STATE(S): MI
WC 21 03 04 (00)-001 MICHIGAN LAW ENDORSEMENT
APPLIES TO STATE(S): MI
WC 22 00 00 (A)-001 MN AMENDATORY ENDT
APPLIES TO STATE(S): MN
WC 22 03 01 (00)-001 MN COMPLIANCE WITH APPLICABLE TRADE LAW
APPLIES TO STATE(S): MN
WC 22 06 01 (D)-001 MINNESOTA CANC AND NON RENEWAL ENDT
APPLIES TO STATE(S): MN
WC 23 06 01 (00)-001 MS CANC NONRENEWAL AND RENEWAL ENDT
APPLIES TO STATE(S): MS

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

WC 24 03 02 (00)-001 MO NOTIFIC OF ADD MESOTHELIOMA BEN ENDT
APPLIES TO STATE(S): MO
WC 24 04 06 (D)-001 MISSOURI EMPLOYER PAID MEDICAL ENDT
APPLIES TO STATE(S): MO
WC 24 06 01 (B)-001 MO CANCELATION AND NON-RENEWAL ENDT.
APPLIES TO STATE(S): MO
WC 24 06 02 (B)-001 MO PROPERTY & CASUALTY GUARANTY ASSOC.
APPLIES TO STATE(S): MO
WC 24 06 04 (C)-001 MISSOURI AMENDATORY ENDORSEMENT
APPLIES TO STATE(S): MO
WC 27 06 01 (C)-001 NV CANCELLATION AND NON RENEWAL ENDT
APPLIES TO STATE(S): NV
WC 28 04 05 (00)-001 NH AUDIT NONCOMPLIANCE CHARGE ENDT
APPLIES TO STATE(S): NH
WC 28 06 01 (00)-001 NH SOLE REPRESENTATIVE END'T
APPLIES TO STATE(S): NH
WC 28 06 04 (00)-001 NH AMENDATORY ENDT
APPLIES TO STATE(S): NH
WC 29 03 06 (B)-001 NJ PART TWO EMPLOYERS LIABILITY ENDT.
APPLIES TO STATE(S): NJ
WC 30 03 01 (00)-001 NM SAFETY DEVICE COVERAGE ENDORSEMENT
APPLIES TO STATE(S): NM
WC 30 04 01 (A)-001 NM WC PREM ADJ PROGRAM
APPLIES TO STATE(S): NM
WC 30 06 01 (A)-001 NM CANCELLATION AND NONRENEWAL END
APPLIES TO STATE(S): NM
WC 31 03 08 (00)-001 NEW YORK LIMIT OF LIABILITY ENDORSEMENT
APPLIES TO STATE(S): NY
WC 31 03 19 (N)-001 NY CONST CLASS PREM ADJUST PROG
APPLIES TO STATE(S): NY
WC 31 04 05 (A)-001 NY SAFE PTNT HNDLG ACT PRGM ENDT FLAT CR
APPLIES TO STATE(S): NY
WC 31 06 18 (A)-001 NEW YORK NOTICE OF RIGHT TO APPEAL
APPLIES TO STATE(S): NY
WC 32 03 01 (D)-001 NORTH CAROLINA AMENDED COVERAGE ENDT
APPLIES TO STATE(S): NC
WC 35 03 03 (00)-001 OK EMP LIAB INTENTIONAL TORT EXCL ENDT
APPLIES TO STATE(S): OK
WC 35 06 01 (F)-001 OK CAN, NONRENEWAL AND CHANGE ENDT
APPLIES TO STATE(S): OK
WC 35 06 03 (00)-001 OK FRAUD WARNING ENDT
APPLIES TO STATE(S): OK
WC 36 03 06 (00)-001 OREGON LIMITS OF LIABILITY
APPLIES TO STATE(S): OR
WC 36 06 01 (E)-001 OR CANCELLATION ENDORSEMENT
APPLIES TO STATE(S): OR
WC 36 06 02 (OO)-001 OREGON CONFIDENTIALITY ENDORSEMENT

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S):	OR
WC 36 06 04 (00)-001	OREGON AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	OR
WC 38 04 01 (B)-001	RI SHORT RATE CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):	RI
WC 38 06 01 (00)-001	RHODE ISLAND DIRECT LIABILITY STATUTE
APPLIES TO STATE(S):	RI
WC 38 06 02 (00)-001	RI SAFETY INSPECTION ENDT
APPLIES TO STATE(S):	RI
WC 39 06 01 (00)-001	SC CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):	SC
WC 42 03 01 (L)-001	TEXAS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	TX
WC 44 06 01 (00)-001	VERMONT LAW ENDORSEMENT
APPLIES TO STATE(S):	VT
WC 44 06 02 (C)-001	VT CANCELLATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):	VT
WC 45 06 02 (00)-001	VA AMENDATORY ENDT
APPLIES TO STATE(S):	VA
WC 47 06 01 (00)-001	WEST VIRGINIA CANCELLATION ENDORSEMENT
APPLIES TO STATE(S):	WV
WC 48 06 01 (C)-001	WISCONSIN LAW ENDORSEMENT
APPLIES TO STATE(S):	WI
WC 48 06 06 (B)-001	WISCONSIN CANCELLATION AND NON RENEWAL
APPLIES TO STATE(S):	WI
WC 52 06 02 (15)-001	HAWAII NOTIFICATION ENDORSEMENT
APPLIES TO STATE(S):	HI
WC 54 03 01 (00)-001	ALASKA LIMIT OF LIABILITY ENDT
APPLIES TO STATE(S):	AK
WC 54 06 01 (A)-001	AK NOTICE OF INSTALLMENT OPTION ENDT
APPLIES TO STATE(S):	AK
WC 54 06 02 (00)-001	ALASKA CANCELATION AND NONRENEWAL ENDT
APPLIES TO STATE(S):	AK
WC 99 01 19 (C)-001	TRIPRA DISCLOSURE ENDORSEMENT
APPLIES TO STATE(S):	WA
WC 99 03 99 (00)-001	CA WORKERS' COMP NOTICE OF NON-RENEWAL
APPLIES TO STATE(S):	CA
WC 99 03 A1 (00)-001	NOTICE OF CANCELATION
APPLIES TO STATE(S):	CO
WC 99 03 F3 (00)-001	CA LIMITS OF LIABILITY ENDT
APPLIES TO STATE(S):	CA
WC 99 04 08 (00)-001	PREMIUM DISCOUNT ENDORSEMENT
APPLIES TO STATE(S):	AK AL AZ CA CO CT DE FL GA HI IA ID IL IN KS KY LA MA MD ME MI MN MO MS NC NH NV NY OK OR RI SC VA VT WA WI WV
WC 99 04 10 (00)-001	PREMIUM ADJ. FROM EFFECTIVE DATE ENDT.
APPLIES TO STATE(S):	CA
WC 99 04 28 (00)-001	PREMIUM MANUALS AND DUE DATE ENDORSEMENT

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

SPECIAL PROVISIONS ENDORSEMENT
STATE APPLICABILITY

The listed endorsements are only applicable in the following states:

APPLIES TO STATE(S):	AK AL CO GA HI IA IL KS KY LA MD ME MO MS NH NM NV OK RI SC TN VA VT WV
WC 99 06 36 (B)-001	CANCELLATION AMENDMENT - WASHINGTON
APPLIES TO STATE(S):	WA
WC 99 06 46 (00)-001	ILLINOIS AMENDATORY ENDORSEMENT
APPLIES TO STATE(S):	IL
WC 99 06 F4 (00)-001	MANAGED CARE PROGRAM ENDORSEMENT
APPLIES TO STATE(S):	CT KY MA NH OK OR RI WV
WC 99 06 K2 (A)-001	WEST VIRGINIA EMPLOYERS LIABILITY ENDST
APPLIES TO STATE(S):	WV
WC 99 06 P5 (00)-001	WC AND EMPL LIAB INFO PAGE-OK AMEND ENDT
APPLIES TO STATE(S):	OK
WC 99 06 T1 (00)-001	NY NOTICE CANCEL DESIGNATED GOV ENTITY
APPLIES TO STATE(S):	NY

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

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

POLICY NUMBER: UB-1T152983-25-14-G

CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 04 28 (00)

POLICY NUMBER: UB-1T152983-25-14-G

PREMIUM MANUALS AND DUE DATE ENDORSEMENT

This endorsement amends Part Five – Premium of the policy as follows:

The following is added to Section **A.**, **Our Manuals**:

Our manuals means manuals that apply to the determination of premium for this policy and that have been:

1. Developed in any format;
2. Filed with the appropriate state insurance regulatory authority by the state-designated workers compensation rating or advisory organization on our behalf, by the respective state rating bureau on our behalf, or by us; and
3. Approved for use by the appropriate state insurance regulatory authority, or otherwise authorized by applicable law.

The following replaces Section **D.**, **Premium Payments**:

D. Premium Payments

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

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

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

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

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 99 06 36 (B)

POLICY NUMBER: UB-1T152983-25-14-G

WASHINGTON AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Washington is shown in theSchedule of the Employers Liability Coverage Endorsement that is part of this policy.

1. The following replaces the last sentence of Paragraph **D.**, **We Will Defend**, of **PART TWO – EMPLOYERS LIABILITY INSURANCE** :

Our right and duty to defend ends when we have exhausted the applicable limit of liability in the payment of judgments or settlements, or we mutually agree otherwise.

2. The following replaces Paragraph **E.**, **Final Premium**, of **PART FIVE – PREMIUM** :

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 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 on the policy.

If this policy is canceled, final premium will be determined in the following way :

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 and you are not retiring from business, 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 procedures. Final premium will not be less than the minim um premium.

3. If you cancel and you are retiring from business, final premium will be calculated pro rata based on the time this policy was in force and will not be less than the pro rata share of the minimum premium .

3. The following replaces Paragraph **D.**, **Cancelation**, of **PART SIX – CONDITIONS** :

D. Cancelation

1. You may cancel this policy by providing us with advance notice using one of the following methods:

a. Written notice of cancellation to us or our agent by mail, fax or email;

b. Surrender of the policy to us or our agent; or

c. Verbal notice to us or our agent.

If we or our agent receives such notice, we will cancel this policy, or any binder issued as evidence of coverage, effective on the later of:

a. The date notice was received; or

b. The date of cancelation that you have requested.

If you provide verbal notice of cancelation to us, we may require you to provide written confirmation of cancelation, but we may not impose a waiting period for cancelation by requiring such written confirmation.

2. We may cancel this policy by delivering or mailing to you, and to each pledgee or other person shown in this policy to have interest in any loss which may occur under this policy, written notice of cancelation at least:

a. Ten days before the effective date of cancelation, if we cancel for nonpayment of premium; or

b. Forty-five days before the effective date of cancelation, if we cancel for any other reason.

3. Notice of cancelation will state the actual reason for cancelation and the effective date of cancelation.

4. Mailing of the notice to you at your mailing address last known to us will be sufficient to prove notice.

4. The following is added to **PART SIX – CONDITIONS** :

Nonrenewal

We will renew this policy unless:

1. We deliver or mail to you, at your address last known to us, written notice stating the actual reason for nonrenewal, at least 45 days before the ex piration date of the policy;

2. At least 20 days before the expiration date of this policy, we have communicated to you or your agent in writing our willingness to renew this policy and have included in that writing a statement of the amount of the premium you are required to pay to renew the policy, and you have failed to discharge when due your obligation in connection with the payment of such premium; or

3. You have procured equivalent coverage before the expiration date of this policy.

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective Policy No. EndorsementNo.

Insured Premium$

Insurance Company Countersigned by_____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 F4(00)

POLICY NUMBER: UB-1T152983-25-14-G

MANAGED CARE PROGRAM ENDORSEMENT

This endorsement applies only to the insurance provided by this policy for the states listed in the schedule below.

This endorsement provides for the payment of benefits under the Workers' Compensation law for medical services and health care to injured workers for compensable injuries and diseases by means of a MANAGED CARE PROGRAM which meets the requirements established by the state. Managed Care Programs are approved on a county by county basis in most states. As an employer you have a responsibility to your employees to comply with the requirements of each county as applicable.

SCHEDULE

Item #1 (STATES)

WV

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

WEST VIRGINIA EMPLOYERS LIABILITY ENDORSEMENT

This endorsement applies only to work in the state of West Virginia.

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

This insurance does not cover:

13. bodily injury to an employee when you are deprived by common law defense or are subject to penalty because of your failure to secure your obligations under the Workers Compensation law of West Virginia or otherwise fail to comply with the law.

14. bodily injury for which you are liable under West Virginia Annotated Code 23-4-2(d)(2)(A).

However, this exclusion does not apply to any bodily injury for which you are liable arising out of West Virginia Annotated Code 23-4-2(d)(2)(B).

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 21 (E)

POLICY NUMBER: UB-1T152983-25-14-G

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (Other Than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 C), 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 the Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
  - **a.** It is an act that is violent or dangerous to human life, property, or infrastructure;
  - **b.** The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
  - **c.** It is an act that has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

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

Schedule

State	Rate	Premium

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

Form WC 00 04 21 (E)

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 21 (F)

POLICY NUMBER: UB-1T152983-25-14-G

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

This endorsement is notification that we are 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). Coverage for such losses is subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations. This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement attached to this policy.

For purposes of this endorsement, Catastrophe (Other Than Certified Acts of Terrorism) is defined as: A single event or peril resulting in a group of claims with aggregate workers compensation losses in excess of $50 million. This $50 million threshold applies per occurrence, across all states for which claims arise from a single event or peril.

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

Schedule

State	**Rate**	**Premium**

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

Form WC 00 04 21 (F)

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 04 08 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

PREMIUM DISCOUNT ENDORSEMENT

The premium for the state and other states, if any, listed in item 3.A of the Information Page may be eligible for a discount. The final calculation of premium discount will be determined by our manuals and your premium as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

OTHER POLICIES:

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 04 10 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

PREMIUM ADJUSTMENT FROM EFFECTIVE DATE ENDORSEMENT

It is agreed that the premium for the policy is subject to an experience modification not available at the time of policy issuance. Such experience modification, when determined, will be stated in an endorsement issued to form a part of the policy.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (C)

POLICY NUMBER: UB-1T152983-25-14-G

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. 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.

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 2019.

"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, 2021, and ending on December 31, 2027, 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.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 01 19 (C)

POLICY NUMBER: UB-1T152983-25-14-G

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed $200,000,000, 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.

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

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

Endorsement Effective | Policy No. | Endorsement No.

Insured | Premium $

Insurance Company | Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 00 04 19 (00)

POLICY NUMBER: UB-1T152983-25-14-G

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE

PREMIUM

D. Premium is amended to read:

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 04 09 (00)

POLICY NUMBER: UB-1T152983-25-14-G

FLORIDA PREMIUM DUE DATE ENDORSEMENT

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

Part Five—Premium, Section D. (Premium Payments) is replaced by the following provision:

D. Premium Payments

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

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective | Policy No. | Endorsement No.

Insured | Premium $

Insurance Company | Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

ENDORSEMENT WC 09 06 09 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

FLORIDA CANCELLATION AND NONRENEWAL ENDORSEMENT

This endorsement applies because Florida is shown in Item 3.A. of the Information Page. Part Six—Conditions, Section D. of the policy is replaced by the following:

D. Cancellation

1. You may cancel this policy by giving a written request to us stating when the cancellation is to take effect. If you do not specify the cancellation effective date in your written request, the cancellation is effective on the date of your written request. We are not required to send notice of cancellation to you if you requested the cancellation in writing. Any retroactive assumption of coverage and liabilities under this policy may not exceed 21 days.
2. We may cancel this policy by giving the first-named insured written notice of cancellation, including in the written notice the reason or reasons for the cancellation.
   a. We must give at least 10 days' written notice prior to the effective date of cancellation when the cancellation is for nonpayment of premium.
   b. We must give at least 30 days' written notice prior to the effective date of cancellation when the policy has been in effect for 60 days or less and the policy is cancelled for reasons other than nonpayment of premium, except where there has been a material misstatement or misrepresentation or failure to comply with our underwriting requirements, then at least 45 days' written notice is required.
   c. We must give at least 45 days' written notice prior to the effective date of cancellation when the policy has been in effect for 61 days or more and the policy is cancelled for reasons other than nonpayment of premium.
   d. When the policy has been in effect for 61 days or more, we may cancel the policy only when there is
      (1) a material misstatement
      (2) a nonpayment of premium
      (3) a failure to comply with our underwriting requirements that we established within 60 days of the effective date of coverage
      (4) a substantial change in the risk covered by the policy, or
      (5) a cancellation for all insureds under such policies for a given class of insureds.
3. If we decide not to renew this policy, we must give the first-named insured written notice of nonrenewal at least 45 days prior to the expiration date of the policy. The written notice will state the reasons for the nonrenewal.

4. If we fail to provide written notice of cancellation or nonrenewal to the first-named insured within the required time frame, the coverage provided to the named insured under this policy will remain in effect until 45 days after the notice is given or until the effective date of replacement coverage obtained by the named insured, whichever occurs first. The premium for the coverage will remain the same during any such extension period except that, in the event of failure to provide notice of nonrenewal, if the rate filing then in effect would have resulted in a premium reduction, the premium during such extension of coverage must be calculated based upon the later rate filing.
5. The policy period will end on the day and hour stated in the cancellation notice.
6. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

All other policy terms, conditions, and exclusions remain unchanged.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 04 01 (C)

POLICY NUMBER: UB-1T152983-25-14-G

ARIZONA ALCOHOL – AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

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

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

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

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

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

1. Insurers offering the premium credit program may apply a 5% premium credit to qualifying employers.

2. To receive the premium credit, you must:

- **a.** Provide a written statement to the insurer prior to or within 30 days after the beginning of the policy effective date each year, certifying that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14.
- **b.** At any time during the term of the policy, provide additional information to the insurer, as required, to confirm that a qualifying program has been established and is being maintained.
- **c.** Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, Article 14.
- **d.** Conduct alcohol and drug testing of prospective employees.
- **e.** Conduct alcohol and drug testing of an employee after the employee has been injured.
- **f.** Allow us to have access to the alcohol and drug testing results under d. and e. above.

3. The determination that you have established and maintain a qualifying program must be made during each policy term that you receive the premium credit.

4. Your certification and any other information relied upon by the insurer in granting the premium credit must be kept in the insurer's underwriting files and made available to the Department of Insurance upon request .

5. The premium credit may be applied after total premium has been paid for the policy period and may be revised at final audit to the employer's policy. The credit is applicable as a supplement to deviated rates and is applied in a multiplicative manner, after the application of the experience modification, and before the application of the premium discount and expense constant.

6. You must reimburse the premium credit if it is determined that you were not in compliance with the provisions of the program.

7. Minimum premium policies are eligible for this premium credit.

8. Residual market employers are eligible to apply for this premium credit.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 06 01 (C)

POLICY NUMBER: UB-1T152983-25-14-G

ARIZONA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

D. Cancellation and Nonrenewal

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. If you cancel or fail to renew this policy, we must promptly notify the Industrial Commission of Arizona.
3. We may cancel this policy if you fail to pay premium when due, or when one or both of the parties to a professional employer agreement terminate the agreement.
   - If we cancel or nonrenew this policy, we must provide to you and the Industrial Commission of Arizona at least 30 days' notice of the cancellation or nonrenewal.
   - Notice to you may be sent via mail or delivered by electronic means as follows:
     - Mailing that notice to you at your last-known mailing address on file with us will be sufficient proof of notice.
     - Delivery to an email address at which you have consented to receive notices or documents.
     - Posting on a portal, secure website, electronic network or site accessible via the Internet or a mobile application, computer, mobile device, tablet, or other electronic device, together with a separate notice that includes a description of the document or notice that was posted and that was provided by email to the email address at which you consented to receive notice, or by any other delivery method to which you consented.
     - If you consented to have the notice emailed in accordance with Arizona law, emailing that notice to you at your last-known email address as provided by you to us will be sufficient proof of notice.
       - If the email notice is: (1) rejected for delivery; (2) returned to us; or (3) we become aware that the email address provided by you is no longer valid, then we will also mail that notice to you by US Postal Service certified mail, certificate of mailing, or first-class mail using intelligent mail barcode, or another similar tracking method used or approved by the US Postal Service.
   - If we nonrenew this policy and fail to give you notice of nonrenewal, coverage will not extend beyond the policy period.
4. The policy period will end on the date and time stated in the cancellation or nonrenewal notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium $
Insurance Company	Countersigned by_____	

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 02 06 03 (A)

POLICY NUMBER: UB-1T152983-25-14-G

ARIZONA AMENDATORY ENDORSEMENT

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

Item 2. of the Information Page is replaced by the following:

2. The policy period is from 02-15-25 to 02-15-26 12:01 a.m. in the time zone of the insured's mailing address. For endorsements issued during the policy period, the effective date is in the time zone of the insured's mailing address.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

Form WC 02 06 03 (A)
(Ed. 12-2022)
DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 04 03 17 (B)

POLICY NUMBER: UB-1T152983-25-14-G

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

The insurance under this policy is limited as follows: It is AGREED that, anything in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

NO LIABILITY FOR EMPLOYEE INSURED BY GENERAL EMPLOYER

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

This policy will be deemed unlimited to the extent that any of the following requirements are not met: (1) the employer actually obtains coverage for the excluded liability and (2) such coverage remains in effect for the term of this policy.

Nothing in this endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations in this endorsement.

It is further agreed that "remuneration" when used as a premium basis for such insurance as is afforded by this policy shall not include the remuneration of any person excluded from coverage in accordance with the foregoing.

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 17 (B)

POLICY NUMBER: UB-1T152983-25-14-G

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 45 (A)

POLICY NUMBER: UB-1T152983-25-14-G

ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE
Comprehensive Personal Liability Policy Exclusion

The insurance under this policy is limited as follows: It is AGREED that, any thing in this policy to the contrary notwithstanding, this policy DOES NOT INSURE:

THIS POLICY DOES NOT INSURE ANY EMPLOYEE(S) COVERED BY A COMPREHENSIVE PERSONAL LIABILITY POLICY

Any liability you may have for any injury to any employee(s) who is covered for workers' compensation benefits on a policy also affording comprehensive personal liability insurance which has been issued to this insured.

Nothing in this endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements, or limitations of this endorsement

It is further agreed that "remuneration" when used as a premium basis for such insurance as is afforded by this policy shall not include the remuneration of any person excluded from coverage in accordance with the foregoing.

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 04 03 60 (B)

POLICY NUMBER: UB-1T152983-25-14-G

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT CALIFORNIA

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

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

A. How This Insurance Applies

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

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

2. The employment must be necessary or incidental to your work in California.

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

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

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

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

1. Exclusion 1 is amended to read as follows:

1. liability assumed under a contract.

2. Exclusion 2 is deleted.

3. Exclusion 7 is amended to read as follows:

7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.

4. The following exclusions are added:

1. bodily injury to any member of the flying crew of any aircraft.

2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.

3. liability arising from California Labor Code Section 2810.3 which relates to labor contracting.

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

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

Endorsement Effective | Policy No. | Endorsement No.

Insured | Premium

Insurance Company | Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 21 (00)

POLICY NUMBER: UB-1T152983-25-14-G

OPTIONAL PREMIUM INCREASE ENDORSEMENT – CALIFORNIA

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

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

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

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured	Insurance Company	

Countersigned By _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-1T152983-25-14-G

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

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

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancelation table below:

Short Rate Cancelation Table

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-1T152983-25-14-G

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-1T152983-25-14-G

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

CALIFORNIA CANCELATION ENDORSEMENT

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

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

Cancelation:

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

2. We may cancel this policy for one or more of the following reasons:

- **a.** Non-payment of premium;
- **b.** Failure to report payroll;
- **c.** Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
- **d.** Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
- **e.** Material misrepresentation made by you or your agent;
- **f.** Failure to cooperate with us in the investigation of a claim;
- **g.** Material failure to comply with federal or state safety orders or written recommendations of our designated loss control representatives;
- **h.** The occurrence of a material change in the ownership of your business;
- **i.** The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
- **j.** The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
- **k.** The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.

3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Items (g) through (k), we will give you 30 days advance written notice; however, we agree that in the event of cancelation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.

4. If we mail the notice to you, the stated periods of notice and your right to remedy the condition will be extended by 5 days if the place of mailing and your mailing address is within California, 10 days if the place of mailing or your mailing address is outside of California and 20 days if the place of mailing or your mailing address is outside of the United States.

5. The policy period will end on the day and hour stated in the cancelation notice.

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

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 05 04 02 (00)

POLICY NUMBER: UB-1T152983-25-14-G

COLORADO CLASSIFICATION ENDORSEMENT

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

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassification was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph:

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 06 03 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

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

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

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

1) Injury by accident must occur during the policy period.

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 06 03 03 (C)

POLICY NUMBER: UB-1T152983-25-14-G

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

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

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer. The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 06 06 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT

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

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

F. Nonrenewal

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intention not to renew. Advance notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

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

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

G. Renewal

We may elect to renew the policy. In accordance with Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intent to renew if, compared to this policy, the terms or conditions of the renewal policy include any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles.

This conditional renewal notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

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

This conditional renewal notice will include or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 07 04 08 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

DELAWARE MERIT RATING PLAN ENDORSEMENT

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

The premium for this insurance may be subject to merit rating plan adjustment because your premium may be less than the amount necessary to be eligible for the Uniform Experience Rating Plan.

The following premium discount or surcharge will be applied to your manual premium based on your claims during the most recent three year period for which statistics are available.

1. A 5% credit (discount) will be applied if you had no compensable employee lost-time injuries – **Statistical Code 9885**.
2. No credit or debit will be applied if you had one (1) compensable employee lost-time injury **– Statistical Code 9884**.
3. A 5% debit (surcharge) will be applied if you had two (2) or more compensable employee lost-time injuries – **Statistical Code 9886**.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 07 06 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

DELAWARE NONRENEWAL ENDORSEMENT

We may elect not to renew the policy. By certified mail we will mail to you, not less than 60 days advance written notice, when the nonrenewal will take effect. Mailing that notice to you at your mailing address, shown in Item 1 of the Information Page, will be sufficient to prove notice.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 03 03 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

This endorsement applies 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 the final mail audit or refuse to cooperate in completing the final physical audit or final physical onsite audit, you must pay us a premium 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 final mail audit or complete the final physical audit or final physical onsite audit.
2. We document the audit file regarding the two good faith attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records or gain access to your premises or your worksites, we send a letter by certified mail to you advising you of the specific records that are required or the premises or worksites that must be accessed and the premium that will be charged if you continue to refuse access to the records, premises, and/or worksites.

If you do not provide all the specific records required and/or fail to permit access to your premises or worksites as applicable, 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 reopen 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 the specific records required and/or permit access to the premises or worksites as applicable 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.

If we cannot complete the audit because you do not permit us to make a physical inspection of your operation or provide us with the necessary records, you must pay us $500 to defray the costs of the audit. The $500 charge may be imposed only if we have incurred actual travel expenses and we notified you in writing of the potential charge when access was denied. Denial of access to records and your premises or worksites by your agent or representative is considered the same as a denial by you.

If you understate or conceal payroll, or misrepresent or conceal employee duties to avoid proper classification for premium calculations or misrepresent or conceal information pertinent to the calculation and application of an experience rating modification factor, then you, your agent or your attorney, must pay us a penalty charge of 10 times the difference in the amount of premium that you paid and the amount that you should have paid and reasonable attorney's fees. The penalty may be enforced in the Florida circuit courts.

At the end of each quarter, you must submit to us a copy of the quarterly earnings reports you filed with the Florida Department of Revenue and any self-audits supported by the quarterly earnings report. The report must include a sworn statement by an officer or principal of your company attesting to the accuracy of the information in it. If you have an employee who suffered a compensable injury and was not reported as having earned wages on your last quarterly earnings report, you must indemnify us for all workers compensation benefits paid to or on behalf of the employee unless you establish that the employee was hired after the filing of the quarterly report, in which case you and the employee must attest to fact that the employee was employed by you at the time of injury.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 04 07 (A)

POLICY NUMBER: UB-1T152983-25-14-G

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

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

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 06 06 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: **UB-1T152983-25-14-G**

GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDORSEMENT

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

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

D. Cancellation, Nonrenewal, and Change

1. You may cancel this policy. You must mail or deliver advance notice to us in writing, or deliver advance notice orally or electronically, stating when the cancellation is to take effect. We may require that you provide written, electronic, or other recorded verification of the request before the cancellation takes effect. The cancellation is subject to the following:

a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.

b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practical after receiving your request for cancellation.

Our notice will state the effective date of cancellation, which will be the later of the following:

1) 10 days from the date of mailing or delivering our notice, or

2) The effective date of cancellation stated in your notice to us.

2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium, or if we nonrenew this policy, we must send a notice of cancellation or nonrenewal by certified mail, return receipt requested, to you at your last address of record at least 75 days before the effective date of cancellation or nonrenewal.

3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience rating modification or resulting from an audit of auditable coverages), we must deliver a notice of our action (including dollar amount of the increase in renewal premium more than 15%) to you, by first class mail, at your last address of record at least 45 days before the expiration date of this policy.

4. If we reduce the policy coverage, we must provide you with written notice at least 45 days before the effective date of the reduction in coverage. The notice will be delivered to you in person or by first class mail to your last address of record. A reduction in coverage made by us includes elimination of coverage, a decrease in scope or less coverage, or the addition of an exclusion. Requests made by you to change, reduce, or eliminate coverage are not considered reductions in coverage.

5. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days before the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.

6. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

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

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

Endorsement Effective Policy N**o.** Endorsement N**o.**
Insured Premium $
Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

ENDORSEMENT WC 12 06 01 (F)

POLICY NUMBER: UB-1T152983-25-14-G

ILLINOIS AMENDATORY ENDORSEMENT

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

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

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

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

G. Audit

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

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

A. Inspection

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

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

D. Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail to each named insured at the last known mailing address advance written notice stating when the cancellation is to take effect. We will maintain proof of mailing of the notice of cancellation. A copy of all such notices shall be sent to the broker or agent of record, if known, at the last known mailing address. The broker or agent of record may opt to accept notification electronically.
3. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least ten days before the cancellation is to take effect. If we cancel for any other reason, we will mail the notice:
   a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;
   b. At least 60 days before the cancellation is to take effect if the policy has been in force for 61 days or more.

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

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

E. Sole Representative

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

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

F. Nonrenewal

1. We may elect not to renew the policy. We will mail to each named insured the nonrenewal notice at the last known mailing address at least 60 days prior to the expiration of the current policy. We will maintain proof of mailing of the nonrenewal notice. An exact and unaltered copy of such notice will also be sent to the named insured's producer, if known, or the producer of record at the last known mailing address. The named insured's producer, if known, or the producer of record may opt to accept notification electronically.
2. If we fail to give at least 60 days' notice prior to the expiration date of the current policy, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this policy. Additionally, in accordance with 215 ILCS 5/462a, we may be required to provide the named insured with 30 days' written notice prior to the expiration of this policy if the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.
3. Our notice of nonrenewal will provide a specific explanation on the reasons for not renewing.
4. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. You notify us or the producer who procured this policy that you do not want the policy renewed; or

b. You fail to pay all premiums when due; or

c. You obtain other insurance as a replacement of the policy.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 12 06 03 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

ILLINOIS RENEWAL ENDORSEMENT

This endorsement applies because Illinois is shown in Item 3.A. of the Information Page. Part Six–Conditions of the policy is revised by adding the following:

G. **Renewal**

1. We may elect to renew the policy in accordance with 215 ILCS 5/143.17a.
   a. We will provide the named insured with written notice of our intent to renew if, compared to this current policy, the:
      - Renewal policy premium increases by 30% or more, or
      - Changes in deductibles or coverage materially alter the renewal policy.
   b. We will mail or deliver the written renewal notice:
      - To the named insured at the last known mailing address
      - At least 60 days prior to the renewal or anniversary date of this current policy.
   c. If we fail to provide notice 60 days prior to the renewal or anniversary date, but we do mail or deliver the written renewal notice to the named insured not less than 31 days prior to the renewal or anniversary date of this current policy, then we may extend this policy at the current terms and conditions for the period of time needed to equal the 60 day time period required to provide notice of intention to renew.
   d. All renewal notices will also be sent to the producer, if known, or the producer of record, and to the mortgagee or lien holder listed on the policy. The producer, if known, or the producer of record and the mortgagee or lien holder may opt to accept notification electronically.
   e. If we fail to provide renewal notice as required above, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this current policy. The increase in premium is based on the known exposure as of the date of the quotation compared to the premium as of the last day of coverage for the current year's policy, annualized. The renewal premium may be subsequently amended to reflect any change in exposure or reinsurance costs not considered in the quotation.
   f. If we fail to provide the notice of renewal as required, the policy will still terminate on its expiration date if:
      (1) You notify us or the producer who procured this policy that you do not want the policy renewed; or
      (2) You fail to pay all premiums when due; or
      (3) You obtain other insurance as a replacement of the policy.
   g. Proof of mailing or proof of receipt of the notice of intent to renew to the named insured may be proven by a sworn affidavit by the company as to the usual and customary business practices of mailing notice pursuant to 215 ILCS 5/143.17a or may be proven consistent with Illinois Supreme Court Rule 236.
2. We may elect to conditionally renew the policy in accordance with 215 ILCS 5/462a.
   a. For policies issued, delivered, amended, or renewed on or after January 1, 2019 ("this policy") we will provide the employer with written notice of our intent to conditionally renew if, compared to this policy, the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.

b. To determine whether the renewal premium is in excess of 5% above the rate recommendation, we will **not** consider any premium increases generated from the following items:

- Increased loss costs
- Increased exposure units
- The application of an experience rating modification
- The application of a contracting classification premium adjustment program
- The application of a large deductible program
- The application of a retrospective rating plan
- An audit of auditable coverages

c. Mailing or delivering such written notice to the employer at least 30 days in advance of the expiration date of this policy, at the address shown in Item 1. of the Information Page, and to the authorized agent or broker will be deemed sufficient notice under this section.

d. This conditional renewal notice will include a statement that clearly identifies:

(1) The amount of the premium increase or, if the amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based on information available to us at that time

(2) The reason for the increased premium in excess of the rate recommendation filed with the Illinois Department of Insurance

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 15 04 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

KANSAS FINAL PREMIUM ENDORSEMENT

This endorsement changes how the final premium is determined. The change applies only to the premium charged because Kansas is shown in Item 3.A. of the Information Page

- Kansas final premium will not be less than the highest minimum premium for the classifications covered by this policy unless there are two or more classifications covered and the highest rated classification has less than $500 payroll.
- When this occurs the final premium will not be less than one-half of the sum of the two highest minimum premiums for any classifications covered by the policy other than Clerical Office and Salespersons.
- When the highest rated classification has less than $500 payroll and Standard Exception classifications are the only classifications showing payrolls, the final premium will not be less than the minimum premium for the classification showing the highest payroll.
- Final premium for a multiple state policy will be that of the state with the single highest minimum premium, even if that state is on an "if any" basis. If two or more states have the same highest minimum premium, the minimum premium is determined by the state with the largest amount of standard premium.
- Minimum premium is subject to final adjustment at audit and will be determined only on the basis of the classifications developing premium.
- If the final earned premium is less than the minimum premium determined at audit, then that minimum premium must be charged.
- If no classification develops premium, the final premium shall be a flat charge of $200.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 15 06 01 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

KANSAS CANCELATION AND NONRENEWAL ENDORSEMENT

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

The Cancelation Condition of the policy is replaced by these two Conditions:

Cancelation

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

2. We may cancel this policy. If we cancel because you fail to pay all premium when due, we will mail or deliver to you not less than 10 days advance written notice stating when the cancelation is to take effect. If we cancel for any other reason, we will mail or deliver to you not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing notice to you at your la st known address will be sufficient to prove notice.

3. If this policy has been in effect for 90 days or more, we may cancel only for one of the following reasons:

a. nonpayment of premium;

b. the policy was issued because of a material misrepresentation;

c. you violated any of the material terms and conditions of the policy;

d. there are unfavorable underwriting factors, specific to you, that were not present when the policy took effect;

e. the Commissioner has determined that our continuation of coverage could place us in a hazardous financial condition or in violation of the laws of Kansas; or

f. the Commissioner has determined that we no longer have adequate reinsurance to meet our needs.

4. Our notice of cancelation will state our reasons for canceling.

5. The policy period will end on the day and hour stated in the cancelation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice when the nonrenewal will take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 03 05 (00)

POLICY NUMBER: UB-1T152983-25-14-G

KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE ENDORSEMENT

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

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

F. Payments You Must Make

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

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

Nonrenewal

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

the policy was not renewed and the date on which coverage ceased to exist. Proof of mailing of the renewal premium to us or our agent on or before the due date will constitute a presumption of receipt on or before the due date.

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 06 02 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

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

NOTICE OF YOUR RIGHTS

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

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

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

TRAVELERS J
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 17 06 01 (J)

POLICY NUMBER: UB-1T152983-25-14-G

LOUISIANA AMENDATORY ENDORSEMENT

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

Part Two – Employers Liability Insurance, Section I. (Actions Against Us) of the policy is replaced by the following:

I. **Actions Against Us**

You may not bring an 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.

The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

Part Five – Premium, Section E. (Final Premium) of the policy is replaced by the following:

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 that 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 calculated using one of the following methods as listed in the Schedule of this endorsement:
   a. Pro rata based on the time that this policy was in force. Final premium will not be less than the pro rata share of the minimum premium, or
   b. More than pro rata; it will be based on the time that this policy was in force, and increased by our short-rate cancellation procedure that has been filed with and approved by the commissioner. Final premium will not be less than the minimum premium.

Part Five – Premium, Section G. (Audit) of the policy is revised by adding the following:

G. **Audit**

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 equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge, and the maximum dollar amount, is shown in the Schedule of this endorsement.

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 Five – Premium, Section 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.

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

D. **Cancellation**

For Home and Community-Based Services (HCBS) providers, refer to Section G. in lieu of Section D. for cancellation provisions.

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you at the mailing address shown on the policy or your last address of record at least 60 days before the cancellation effective date, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered at least 10 days before the effective date of cancellation. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:
   a. Nonpayment of premium
   b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Activities or omissions on your part that change or increase any hazard insured against, including a failure to comply with loss control recommendations
   d. Change in the risk that increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
   e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
   f. Violation or breach by the insured of any policy terms or conditions
   g. Such other reasons that are approved by the commissioner of insurance
2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions 1.b. through 1.g. of Section D-1 will be mailed or delivered at least 30 days before the effective date of the cancellation; notices of cancellations based on condition 1.a. of Section D-1 will be mailed or delivered at least 10 days before the effective date of cancellation. The notice will state the effective date of the cancellation.
   b. We will provide you with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:
      (1) Giving notice of or specifying the reasons for a cancellation, or
      (2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement

3. We will provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.
4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or your last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss-run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the policy expiration date will be considered pro rata based on the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.
5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.
6. If we provide the notice described in paragraph 4 above and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.
7. We must mail or deliver to you at the mailing address shown on the policy or your last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage at least 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy' s rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first. For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice. If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any, and other changes will be effective the day following the prior policy' s expiration date.
8. Paragraph 7 does not apply to changes:
    a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business
    b. Based on the altered nature or extent of the risk insured
    c. In policy forms filed and approved with the commissioner and applicable to an entire class of business
    d. Requested by the insured
9. Proof of mailing or delivery of notice of cancellation, or of nonrenewal, or of premium or coverage changes, to the named insured at the mailing address shown in the policy or the last address of record, will be sufficient proof of notice.

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

F. **Your Right to Remove Agent**

We will not change or remove the agent of record who wrote this policy before the termination or renewal of this policy unless you request the change or removal. If you request the change or removal of the agent, we will notify the agent in writing 10 calendar days before the change or removal.

Schedule

1. If you cancel, final premium for this policy will be calculated: pro rata, or X more than pro rata

2.	**Basis of Audit Noncompliance Charge**	**Maximum Audit Noncompliance Charge Multiplier**	**Audit Noncompliance Charge $ Amount**
	Estimated Annual Premium	50.00 %	$ 47 (Subject to recalculation based on actual premium at the end of the policy period)

Part Six – Conditions, Section D. (Cancellation) of the policy is replaced for Home and Community-Based Services (HCBS) providers by adding Part Six – Conditions, Section G. The following cancellation provisions are to be used when the policy provides coverage to an HCBS provider and are intended to comply with Chapter 50 of the Louisiana Administrative Code, Title 48, Part I, Sections 5007, 5014, and 5015:

G. **Cancellation – Home and Community-Based Services (HCBS) Providers**

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record 60 days before any cancellation or change of coverage, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered 30 days before the effective date of cancellation. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:
   a. Nonpayment of premium
   b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Activities or omissions on your part that change or increase any hazard insured against, including a failure to comply with loss control recommendations
   d. Change in the risk that increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
   e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
   f. Violation or breach by the insured of any policy terms or conditions
   g. Such other reasons that are approved by the commissioner of insurance
2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions

1.a. through 1.g. of Section G-1 will be mailed or delivered 30 days before the effective date of the cancellation. The notice will state the effective date of the cancellation.

b. We will provide you and the certificate holder (LDH Health Standards Section) with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:

(1) Giving notice of or specifying the reasons for a cancellation, or

(2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement

3. We will provide a notice of cancellation or a statement of reasons for cancellation to you and the certificate holder (LDH Health Standards Section) where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.

4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or your last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss-run information for the period the policy has been in force within, but not to exceed, the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after the notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the policy expiration date will be considered pro rata based on the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.

5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.

6. If we provide the notice described in paragraph 4 above, and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.

7. We must mail or deliver to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or the last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy's rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first. For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice. If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any, and other changes will be effective the day following the prior policy' s expiration date.

8. Paragraph 7 does not apply to changes:

a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business

b. Based on the altered nature or extent of the risk insured

c. In policy forms filed and approved with the commissioner and applicable to an entire class of business

d. Requested by the insured

9. Proof of mailing or delivery of notice of cancellation, or of nonrenewal, or of premium or coverage changes to the named insured and the certificate holder (LDH Health Standards Section) where applicable at the mailing address shown in the policy or at the last address of record, will be sufficient proof of notice.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 17 06 02 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

LOUISIANA COST CONTAINMENT ACT ENDORSEMENT

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

You may be eligible for a two (2) percent reduction in your premium if you attend a cost containment meeting conducted by the Occupational, Safety and Health administration (OSHA) Section of the Office of Workers Compensation Administration. In order for you to receive the reduction you must submit to us a certificate of attendance from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date you attended the cost containment meeting.

You may also be eligible for an additional five (5) percent reduction in your premium if you have attended a cost containment meeting and have subsequently satisfactorily implemented an occupational, safety and health program prescribed by the OSHA Section. In order for you to receive the reduction you must submit to us a Certificate of Satisfactory Implementation of Occupation, Safety and Health Program from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date of your certification.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 18 06 01 (00)

POLICY NUMBER: UB-1T152983-25-14-G

MAINE INSPECTION IMMUNITY ENDORSEMENT (TITLE 14 MAINE REVISED STATUTES ANNOTATED SECTION 167) THE FOLLOWING LIMITS OUR LIABILITY

We, the insurance company, our agents, employees, or service contractors, are not liable for damages from injury, death or loss occurring as a result of any act or omission in the furnishing of or the failure to furnish insurance inspection services related to, in connection with or incidental to the issuance or renewal of a policy of property or casualty insurance.

This exemption from liability does not apply:

A. If the injury, loss or death occurred during the actual performance of inspection services and was proximately caused by our negligence or by the negligence of our agents, employees or service contractors;

B. To any inspection services required to be performed under the provisions of a written service contract or defined loss prevention program;

C. In any action against us, our agents, employees, or service contractors for damages proximately caused by our acts or omissions which are determined to constitute a crime, actual malice or gross negligence; or

D. If we fail to provide this written notice to the insured whenever a policy is issued or when new policy forms are issued upon renewal.

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 18 06 03 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

MAINE CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

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

2. We may cancel this policy. We must mail or deliver to you and to the Workers Compensation Board not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.

3. The policy period will end on the day and hour stated in the cancelation notice. If you have obtained a workers compensation and employers liability insurance policy from another insurance company, or have otherwise secured your obligation to provide compensation, and such insurance or other security becomes effective prior to the expiration of the notice period, the policy period will end on the effective date of such other insurance or security.

4. If this policy has been renewed or has been in effect for 60 days or more, we may cancel only for one of the following reasons:

- **a.** Nonpayment of premium;
- **b.** Fraud or a material misrepresentation was made in obtaining the policy, continuing the policy or presenting a claim under the policy.
- **c.** The risk accepted when the policy was issued has substantially increased;
- **d.** Your failure to comply with reasonable loss control recommendations;
- **e.** A substantial breach of contractual duties, conditions or warranties under the policy;
- **f.** The Superintendent has determined that continuation of the policy could jeopardize our solvency or place us in violation of the law.

Nonrenewal

We may elect not to renew the policy. We will mail or deliver to you not less than 30 days advance written notice. A post office certificate of mailing to you at your last known address will be conclusive proof of receipt of that notice on the third calender day after mailing.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 18 06 04 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MAINE FINAL PREMIUM AUDIT ENDORSEMENT

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

Part Five (Premium), Condition E, Final Premium, and Condition G, Audit, are changed by adding these conditions:

E. Final Premium

We are required by Maine regulation to complete our final premium audit no later than 120 days after the policy period ends.

If we are unable to examine and audit your records because of your failure to cooperate, we will mail advance written notice to you stating the reasons for our inability to establish the final premium. Your final premium will be established no later than 120 days from the time we are able to complete the examination and audit of your records.

If we have not established the final premium within the 120-day time limitation, we may not bill or collect any additional premium that exceeds the latest billed annual premium.

G. Audit

You may request a final premium audit to determine whether you are entitled to a refund, if we have not established the final premium within the 120-day time limit. You may mail or deliver written notice to us requesting the audit.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 18 06 06 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MAINE NOTICE OF FILING OF FIRST REPORTS OF INJURY WITHIN SEVEN DAYS ENDORSEMENT

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

Employer's First Report of Occupational Injury or Disease, form WCB-1, required to be filed for injuries arising out of and in the course of an employee's employment that has caused the employee to lose a day's work shall be reported to and received by the Workers' Compensation Board within seven (7) days after the employer receives notice or knowledge of the injury, as provided by 39-A M.R.S.A. sec. 303. First Reports of Injury can be mailed, electronically submitted or faxed to the Workers' Compensation Board at 207-287-5895.

Contact us immediately if an injury occurs which may be required to be reported to the Workers' Compensation Board.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 18 06 07 (A)

POLICY NUMBER: UB-1T152983-25-14-G

MAINE EMPLOYMENT REHABILITATION FUND ENDORSEMENT

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

We are required by the Maine Employment Rehabilitation Fund, to collect a surcharge for this policy to fund payments made in accordance with the reimbursement provisions of Section 355 of Title 39A. Assessments may be levied during this policy period if exigent conditions arise and the balance in the fund is inadequate to discharge reimbursement in a timely fashion.

Schedule

See Schedule page for Surcharge.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 19 06 01 (G)

POLICY NUMBER: UB-1T152983-25-14-G

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

D. **Cancellation and Nonrenewal**

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

   Mailing this notice by certified mail to you at your mailing address last known to us creates a presumption of actual delivery of notice. You may be able to rebut this presumption by providing evidence that the notice was not delivered.
3. The effective dates of the cancellation or nonrenewal are determined as follows:
   a. Except for cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation or nonrenewal notice, or 45 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
   b. For cancellation for nonpayment of premium, the policy period will end on the day and hour stated in the cancellation notice, or 10 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
4. The provisions in D-2 and D-3 do not apply to the cancellation of a policy or binder during the 45-day underwriting period in accordance with Section 12-106 of Maryland Code, Insurance. Refer to Section 12-106 of Maryland Code, Insurance for the cancellation provisions that apply during the 45-day underwriting period.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by_____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 03 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

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

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

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 03 02 (A)

POLICY NUMBER: UB-1T152983-25-14-G

MASSACHUSETTS – ASSESSMENT CHARGE

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER: UB-1T152983-25-14-G

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact your agent or us.

You may obtain pertinent rating information by submitting a written request to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this endorsement or to us at our company address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

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

2. Reserve or Settlements

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

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

3. Named Insured

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

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

4. Insured's Mailing Address

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

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 03 (D)

POLICY NUMBER:UB-1T152983-25-14-G

Addresses

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

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

Address Correspondence as follows:

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

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

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

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

ALL OTHER POLICIES, TO:
The Travelers Insurance Company
P.O. Box 5600
Hartford, CT 06102-5600

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 04 05 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

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

PART FIVE

PREMIUM

D. Premium Payments is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The audit and retrospective premiums shall be paid by the due date indicated on the billing statement.**

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 06 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

MASSACHUSETTS CANCELLATION ENDORSEMENT

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

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

Cancellation

1. You may cancel this policy by mailing or delivering to us advance written notice requesting cancellation. Such cancellation shall not be effective until ten days after written notice is given by us to The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

2. We may cancel this policy only if based on one or more of the following reasons: (i) nonpayment of premium; (ii) fraud or material misrepresentation affecting your policy; or (iii) a substantial increase in the hazard insured against. Such cancellation shall not be effective until ten days after written notice is given by us to you and The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

3. We will mail or deliver the notice of cancellation to you at your last address, which shall be the mailing address shown in Item 1 of the Information Page or the change of mailing address shown in an Endorsement to the Policy. Pursuant to M.G.L. Chapter 175, Section 187C, a written notice of cancellation shall be deemed effective when mailed by us if we obtain a certificate of mailing receipt from the United States Postal Service showing your name and address as stated in the policy.

4. Any of these provisions that conflict with the law that controls the cancellation of this insurance policy is changed by this statement to comply with the law.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 21 03 03 (A)

POLICY NUMBER: UB-1T152983-25-14-G

MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact us or your agent.

You may obtain pertinent rating information by submitting a written request to us at our address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

You may also submit a written request for a review of the method by which your rates and premiums were determined. If you are not satisfied with the results of the review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Payroll Audits

You may request a payroll audit once each calendar year. Your request must be in writing sent to our address shown in this endorsement. You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

You may request reserve and redemption information that relates to the premium for this policy. Your request must be in writing sent to our address shown in this endorsement. We will provide you with that information within thirty (30) days of receipt of your request.

If you believe that the policy premiums are excessive because we set unreasonable reserves or because of the unreasonable redemption of a claim, you may request a meeting with our management representative. Your request must be in writing sent to our address shown in this endorsement. If you are not satisfied with the results of the meeting, you may appeal to the Insurance Commissioner at the address shown in this endorsement.

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30200
Lansing, MI 48909

The Travelers Insurance Companies
1000 Travelers Tower
26555 Evergreen
Southfield, MI 48076
or
3777 Sparks Drive Southeast
Grand Rapids, MI 49546
or
The Travelers
215 Shuman Boulevard
Naperville, IL 60563

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 21 03 04 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MICHIGAN LAW ENDORSEMENT

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

Michigan law requires that we attach this paragraph to your policy in the language specified by the statute. To help you understand the paragraph, the following definitions are added:

(1) We are "the insurer issuing this policy"

(2) You are "the insured employer"

(3) "Michigan workmen's compensation act" means the Workers' Disability Compensation Act of 1969.

(4) "Workmen's compensation" means workers' compensation

(5) "The bureau of workmen's compensation" means the Bureau of Workers' Disability Compensation.

"Notwithstanding any language elsewhere contained in this contract or policy of insurance, the accident fund or the insurer issuing this policy hereby contracts and agrees with the insured employer:

Compensation:

(a) That it will pay to the persons that may become entitled thereto all workmen's compensation for which the insured employer may become liable under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Medical services:

(b) That it will furnish or cause to be furnished to all employees of the employer all reasonable medical, surgical, and hospital services and medicines when they are needed which the employer may be obligated to furnish or cause to be furnished to his employees under the provisions of the Michigan workmen's compensation act and that it will pay to the persons entitled thereto for all such services and medicines when they are needed for all compensable injuries or compensable occupational disease happening to his employees during the life of this contract or policy;

Rehabilitation services:

(c) That it will furnish or cause to be furnished such rehabilitation services for which the insured employer may become liable to furnish or cause to be furnished under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational disease happening to his employees during the life of this contract or policy;

Funeral expenses:

(d) That it will pay or cause to be paid the reasonable expense of the last sickness and burial of all employees whose deaths are caused by compensable injuries or compensable occupational diseases happening during the life of this contract or policy and arising out of and in the course of their employment with the employer, which the employer may be obligated to pay under the provisions of the Michigan workmen's compensation act;

Scope of contract:

(e) That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all

other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations assumed:

(f) That it hereby assumes all obligations imposed upon the employer by his acceptance of the Michigan workmen's compensation act, as far as the payment of compensation, death benefits, medical, surgical, hospital care or medicine and rehabilitation services is concerned;

Termination notice:

(g) That it will file with the bureau of workmen's compensation at Lansing, Michigan, at least 20 days before the taking effect of any termination or cancelation of this contract or policy, a notice giving the date at which it is proposed to terminate or cancel this contract or policy; and that any termination of this policy shall not be effective as far as the employees of the insured employer are concerned until 20 days after notice of proposed termination or cancelation is received by the bureau of workmen's compensation;

Conflicting provisions:

(h) That all the provisions of this contract, if any, which are not in harmony with this paragraph are to be construed as modified hereby, and all conditions and limitations in the policy, if any, conflicting herewith are hereby made null and void."

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 22 00 00 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

MINNESOTA AMENDATORY ENDORSEMENT

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

PART TWO—EMPLOYERS LIABILITY INSURANCE

E. We Will Also Pay is amended to read:

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

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Your share of pre- or postjudgment interest assuming that the principal amount of that judgment is within the applicable policy limits under this insurance; and
5. Expenses we incur.

H. Recovery From Others is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

PART FIVE—PREMIUM

G. Audit is amended to read:

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data.

We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends, except as it pertains to Part Two—Employer's Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

DEFINITIONS

As used in this policy, "rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 22 03 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

MINNESOTA COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS

This endorsement changes the policy to which it is attached effective on the inception of the policy unless a different date is indicated below.

This endorsement, effective on _____ at 12:01 a.m. standard time, forms a part of

Policy No. _____ of the _____
(Name of Insurance Company)

Issued to: _____

Endorsement No. _____ _____
Authorized Representative

Under Part Six – Conditions, the following condition is added:

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

All other terms and conditions remain unchanged.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 22 06 01 (D)

POLICY NUMBER: **UB-1T152983-25-14-G**

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Cancellation of a New Policy

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of Cancellation.

Cancellation of Other Policies

If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

Notice of Cancellation

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or delivered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 22 06 01 (D)

POLICY NUMBER: **UB-1T152983-25-14-G**

Refunds Due You

If this policy is canceled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

1. Insured elsewhere;

2. Accepted replacement coverage; or

3. Requested or agreed not to renew this policy.

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: **UB-1T152983-25-14-G**

MISSISSIPPI CANCELLATION, NONRENEWAL, AND RENEWAL ENDORSEMENT

This endorsement applies because Mississippi 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 on the day you either:

a. Return the policy to the agent

b. Sign and deliver a lost policy release to your agent

If you cancel this policy before it becomes effective, you may submit written notice of cancellation to us or your agent without returning the policy or signing a lost policy release.

2. We may cancel or nonrenew this policy. We will provide you and the Mississippi Workers' Compensation Commission (Commission) with at least 30 days' advance written notice stating when the cancellation or nonrenewal is to take effect. If you obtain other insurance coverage, the date of cancellation will be the effective date of the other coverage. We will provide cancellation and nonrenewal notice to:

a. You personally or by registered or certified mail

b. The Commission in the manner and on the form specified by the Commission

3. The provisions in D-2 do not apply to the cancellation and nonrenewal of this policy when we issue a replacement policy providing the same or substantially similar coverage or when we transfer you to a licensed affiliate carrier providing the same or substantially similar coverage in a replacement policy.

Provisions detailed in Part Six, Section F-2 apply.

4. The policy period will end on the day and hour stated in the cancellation notice.

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

F. Renewal

1. We may elect to renew the policy. If we issue a renewal policy with the same or substantially similar coverage, we will notify you at least 30 days before the renewal policy's effective date, in writing, of any terms or conditions that are less favorable to you.

2. We may elect to transfer this policy to a licensed affiliate carrier. The notification requirements for transferring this policy to a licensed affiliate carrier and for that carrier's issuance of a renewal policy are as follows:

a. At least 45 days before notifying you of the transfer, we must notify the Mississippi Insurance Department and the Commission of the transfer. The notice will include our name (as the carrier transferring the policy) and the name and financial rating of the carrier receiving the transferred policy.

b. We must notify you, in writing, of the transfer at least 30 days before the policy term expires. This notice will be provided with the notice of renewal premium that we are required to send to you. This notice will include the financial rating of the carrier receiving the transferred policy.

c. If we transfer this policy to a licensed affiliate carrier to provide the same or substantially similar coverage, that carrier will notify you at least 30 days before the renewal policy's effective date, in writing, of any terms or conditions that are less favorable to you.

3. The notices will be mailed or delivered to you personally.

4. If a replacement policy is issued, the application and any related documents you signed for the initial policy apply and remain valid and enforceable.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 03 02 (00)

POLICY NUMBER: UB-1T152983-25-14-G

MISSOURI NOTIFICATION OF ADDITIONAL MESOTHELIOMA BENEFITS ENDORSEMENT

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

Section 287.200.4, subdivision (3), of the Missouri Revised Statutes provides additional benefits in the case of occupational diseases due to toxic exposure that are diagnosed to be mesothelioma and result in permanent total disability or death. Your policy provides insurance for these additional benefits.

If you reject liability for mesothelioma additional benefits provided under Section 287.200.4, subdivision (3), of the Missouri Revised Statutes, you must notify us of this election. Once you notify us, we will endorse this policy to exclude insurance for these additional benefits. If you reject liability for mesothelioma additional benefits, the exclusive remedy provisions under Missouri Revised Statutes Section 287.120 shall not apply to your liability for mesothelioma additional benefits.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 24 06 01 (B)

POLICY NUMBER: **UB-1T152983-25-14-G**

MISSOURI CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

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

2. We may cancel this policy. We will mail or deliver to you not less than 60 days advance written notice stating when the cancelation is to take effect and our reason for cancelation. Proof of mailing of this notice to you at your mailing address shown in item 1 of the Information Page will be sufficient to prove notice.

3. The 60-day notice requirement does not apply where cancelation is based on one or more of the following reasons:

- **a.** nonpayment of premium
- **b.** fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;
- **c.** a violation of policy terms;
- **d.** changes in conditions after the effective date of the policy materially increasing the hazards originally insured;
- **e.** our insolvency;
- **f.** our involuntary loss of reinsurance for the policy.

4. The policy period will end on the day and hour stated in the cancelation notice

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice stating when the nonrenewal will take effect and our reason for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in item 1 of the Information Page will be sufficient to prove notice.

2. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:

- **a.** we show you our willingness to renew the policy but you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
- **b.** you fail to pay all premiums when due; or
- **c.** you obtain other insurance as a replacement of the policy.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY**

ENDORSEMENT WC 24 06 02 (B)

POLICY NUMBER: UB-1T152983-25-14-G

MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOCIATION NOTIFICATION ENDORSEMENT

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

Missouri Property and Casualty Insurance Guaranty Association Coverage Limits:

1. Subject to the provisions of the Missouri Property and Casualty Insurance Guaranty Association Act (Act), if we are a member of the Missouri Property and Casualty Insurance Guaranty Association (Association), the Association will pay claims covered under the Act if we become insolvent.

2. The Act contains various exclusions, conditions and limitations that govern a claimant's eligibility to collect payment from the Association and affect the amount of any payment. The following limitation applies subject to all other provisions of the Act:

a. Claims covered by the Association do not include a claim by or against an insured of an insolvent insurer if the insured has a net worth of more than $25 million on the later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis.

If the insured prepares an annual report to shareholders, or an annual report to management reflecting net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurer will be used to determine net worth.

However, the association will not:

(1) Pay an amount in excess of the applicable limit of insurance of the policy from which a claim arises; or

(2) Return to an insured any unearned premium in excess of $25,000.

These limitations have no effect on the coverage we will provide under this policy.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 06 04 (C)

POLICY NUMBER: UB-1T152983-25-14-G

MISSOURI AMENDATORY ENDORSEMENT

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

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

G. **Audit**

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

Audits must be completed and billed, and any premiums will be returned, within 120 days of policy expiration or cancellation unless:

1. Delay is caused by your failure to respond to reasonable audit requests, provided that the requests are timely and adequately documented; or
2. A written agreement between you and us provides a longer time frame.

If you or we have any objection to the results of any audit, you or we may send a written notice demanding a reconsideration of the audit within three years from the date of expiration or cancellation of this policy. The written notice must be based upon sufficiently clear and specific facts as to why the audit should be reconsidered.

If you do not allow us to examine and audit all of your records relating to this policy, and/or do not provide audit information as timely and reasonably requested, we may apply an Audit Noncompliance Charge equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge is shown in the Schedule below.

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

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

Note:

For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 24 06 04 (C)

POLICY NUMBER: UB-1T152983-25-14-G

SCHEDULE

Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
Estimated annual premium	Multiplier varies based on number of consecutive policy periods in which you failed to comply with the Audit provision: - First policy period: 25% - Second consecutive policy period: 50% - Third (or more) consecutive policy period(s): 75%

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

Part Six – Conditions, D. Cancellation of the policy is replaced by the following:

A. Midterm Cancellation

1. You may cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect.

2. We will provide you not less than 10 days notice if this policy is cancelled because you failed to pay a premium or remit an amount due because of an endorsement for a deductible when due.

3. We will provide you not less than 30 days notice for any other cancellation reason permitted under Nevada law, including failure to pay additional premium charged due to an audit of any payroll under the terms of the current or previous policy.

4. No policy of industrial insurance that has been in effect for at least 70 days or that has been renewed may be cancelled, except on any one of the following grounds:

a. A failure by the policyholder to pay a premium for the policy of industrial insurance when due, including the failure of the policyholder to remit an amount due because of an endorsement for a deductible;

b. A failure by the policyholder to:

(1) Report any payroll;

(2) Allow the insurer to audit any payroll in accordance with the terms of the policy or any previous policy issued by the insurer; or

(3) Pay any additional premium charged because of an audit of any payroll as required by the terms of the policy or any previous policy issued by the insurer;

c. A material failure by the policyholder to comply with any federal or state order concerning safety or any written recommendation of the insurer's designated representative for loss prevention;

d. A material change in ownership of the policyholder or any change in the policyholder's business or operations that:

(1) Materially increases the hazard for frequency or severity of loss;

(2) Requires additional or different classifications for the calculation of premiums; or

(3) Contemplates an activity that is excluded by any reinsurance treaty of the insurer;

e. A material misrepresentation made by the policyholder; or

f. A failure by the policyholder to cooperate with the insurer in conducting an investigation of a claim.

5. We cannot cancel the policy when the referenced reasons are corrected by you within the time specified in the written notice of cancellation.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 27 06 01 (C)

POLICY NUMBER: UB-1T152983-25-14-G

B. Nonrenewal

1. We may elect not to renew the policy. We will provide to you a written notice of our intention not to renew at least 60 days before the expiration date.
2. We need not provide notice of our intention not to renew if you have accepted replacement coverage, if you have requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

C. Information About Claims Paid

1. If you request information for the renewal of the policy, we will provide you with information regarding claims paid on your behalf.
2. We will provide the information within 30 working days after we receive your written request. We may charge a reasonable fee for providing the information.

D. Notices

1. We will provide advance written notice of cancellation or nonrenewal as provided in A and B above. This notice must be served personally on or sent by first-class mail or electronic transmission to the employer.
2. Notices will state the effective date of the cancellation or nonrenewal and will be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal.
3. A written notice of cancellation is not required if we mutually agree with you to cancel the policy and reissue a new policy based upon a material change in the ownership or operation of your business.

E. Compliance With Law

1. Any of these provisions that conflict with a law that controls the cancellation or renewal or nonrenewal of the insurance in this policy is changed by this statement to comply with the law.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 28 06 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NEW HAMPSHIRE SOLE REPRESENTATIVE ENDORSEMENT

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

Condition E, "Sole Representative", of the policy is replaced by the following:

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

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 28 06 04 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NEW HAMPSHIRE AMENDATORY ENDORSEMENT

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

For New Hampshire coverage, the Cancelation condition of the policy is amended and replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us.

2. We may cancel this policy. We will file a written termination notice with the Commissioner of the Department of Labor and will send a copy to you.

3. In case of nonpayment of premium, the cancelation will take effect 30 days after the termination notice is filed.

4. In case of cancelation for reasons other than nonpayment of premium, cancelation will take effect 45 days after the notice of termination is filed.

5. If you have obtained coverage from another insurance carrier or have qualified as a self-insurer, cancelation is effective on the date you obtained the coverage or qualified as self-insurer.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 29 03 06 (B)

POLICY NUMBER: UB-1T152983-25-14-G

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

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

With respect to Exclusion C5, this insurance does not cover any and all intentional wrongs within the exception allowed by N.J.S.A. 34:15-8 including but not limited to, bodily injury caused or aggravated by an intentional wrong committed by you or your employees, or bodily injury resulting from an act or omission by you or your employees, which is substantially certain to result in injury.

With respect to Exclusion C7, we will defend any claim, proceeding or suit for damages where bodily injury is alleged. We have the right to investigate and settle. We will not defend or continue to defend after the applicable limits of insurance have been paid. Such policy limits include any legal costs assessed against you on behalf of your employee(s).

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to an infant under the age of 18 years in a proceeding made pursuant to Article 2 as provided in N.J.S.A. 34:15-10.

This insurance does not provide for the payment of any common law negligence damages or other damages when the provisions of Article 2 of the New Jersey Workers Compensation Law have been rejected by you and your employee(s) as provided in N.J.S.A. 34:15-9.

With respect to paragraph F, the "Other Insurance" provision is replaced with the following:

F. Other Insurance

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

This insurance, however, is excess over any other applicable insurance with respect to claims for bodily injury arising out of employer practices, policies, acts or omissions enumerated in C7 above, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 30 03 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NEW MEXICO SAFETY DEVICE COVERAGE ENDORSEMENT

Section 52-1-10 of the New Mexico workers compensation law may make you liable for the payment of additional benefits in the case of bodily injury to employees resulting from your failure to supply safety devices. The benefits payable under Part One (Workers Compensation Insurance) includes these additional benefits.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 30 04 01 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

NEW MEXICO WORKERS COMPENSATION PREMIUM ADJUSTMENT PROGRAM FOR QUALIFYING CLASSIFICATIONS ENDORSEMENT

The premium for the policy may be adjusted by New Mexico Workers Compensation Premium Adjustment credits and Offset to Experience Rating debit. The credits and debit were not available when the policy was issued. If you qualify, or if estimated credits and estimated debit have been applied, we will issue an endorsement to show the proper premium adjustment credits and debit after they are calculated.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 30 06 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

NEW MEXICO CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

D. Cancellation

1. You may cancel this policy by giving us advance written notice stating when the cancellation is to take effect.

2. At any time during the policy period, regardless of the number of days the policy has been in effect, we may cancel this policy for nonpayment of premium when due. We must give written notice to you at least 10 days prior to the effective date of the cancellation.

3. If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel this policy without cause by giving written notice to you at least 10 days prior to the effective date of the cancellation. The cancellation effective date must fall within this period of less than 60 days.

4. Subject to Subsection 2 above, if the policy has been in effect for 60 days or more or is a renewal, we may cancel this policy only for one or more of the following reasons:

a. The policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by us. We must give written notice to you at least 15 days prior to the effective date of cancellation.

b. Willful and negligent acts or omissions by you have substantially increased the hazards insured against. We must give written notice to you at least 15 days prior to the effective date of cancellation.

c. You presented a claim based on fraud or material misrepresentation. We must give written notice to you at least 15 days prior to the effective date of cancellation.

d. There has been a substantial change in the risk assumed by us since the policy was issued. We must give written notice to you at least 30 days prior to the effective date of cancellation.

e. Revocation or suspension of driver's license of the named insured or other operator who either resides in the same household or customarily operates the vehicle. We must give written notice to you at least 15 days prior to the effective date of cancellation.

5. We will give the required Notice of Cancellation stating the reason(s) for cancellation before the cancellation is effective. The notice will state the time that the cancellation is to take effect. The written notice of cancellation will be sent to your last address of record with us.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 30 06 01 (A)

POLICY NUMBER: UB-1T152983-25-14-G

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

F. Nonrenewal

1. If we decide not to renew this policy, we must give you written notice of our intention at least 30 days prior to the expiration of the policy. The written notice of nonrenewal will be sent to your last address of record with us.

2. This nonrenewal section does not apply to any policy of insurance issued to an insured that has its principal place of business outside the state of New Mexico.

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

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

Endorsement Effective	Policy No.	EndorsementNo.
Insured		Premium
Insurance Company	Countersigned by_____	

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 31 03 08 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

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

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

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

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

Credits are earned for average wages in excess of $23.24 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

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

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

The basis for determining the credit is the limited payroll of each employee for the number of hours worked (excluding overtime premium pay) for each construction classification (other than employees engaged in the construction of one or two-family residential housing). For policies with effective dates between January 1 and March 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the second calendar year preceding the policy effective date. For policies with effective dates between April 1 and December 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the calendar year preceding the policy effective date. Total payroll (and not limited payroll) is to be reported for employees engaged in the construction of one or two-family residential housing.

Credits are calculated by the New York Compensation Insurance Rating Board. Completed applications can be submitted to: Attention: Audit Division, New York Compensation Insurance Rating Board, 875 Third Avenue, 8th Floor, New York, New York 10022, email: cpap@nycirb.org or via entry on the CPAP online application on the Rating Board's website http://www.nycirb.org/cpap.

The application for credit on a renewal policy must be received by the Rating Board three (3) months prior to the policy renewal effective date. The Rating Board will accept and process an application if it is received between the

renewal policy effective and expiration date, however, it must be accompanied with an explanation from the employer stating the reason for the delay.

Under no circumstances will an original application be accepted for any policy if it is received after the expiration date of the policy to which the credit would have applied, nor will a revised application be accepted if it is received later than one (1) year from the expiration date of the policy to which the credit would have applied.

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 31 04 05 (A)

POLICY NUMBER: UB-1T152983-25-14-G

NEW YORK SAFE PATIENT HANDLING ACT PROGRAM EXPLANATORY ENDORSEMENT (FLAT CREDIT)

The New York Safe Patient Handling Act Program (NYSPHAP) allows a premium credit for New York employers in the healthcare industry. This credit exists to recognize compliance with Section 2997-k(2) of the New York State Public Health Law.

The Information Page of this policy will show a credit of 2.5% if you are eligible for this credit. You are eligible for a NYSPHAP credit if you are in compliance with the requirements of New York State Public Health Law Section 2997-k(2) and your policy contains classification codes subject to the NYSPHAP, which may include, but are not limited to the following:

8829 "Nursing Home-All Employees"
8833 "Hospital-Professional Employees"
8865 "Alcohol or Drug Rehabilitation Facility – All Employees & Clerical"
8866 "Assisted Living Facility – All Employees & Clerical"
9040 "Hospital-All Other Employees"

Contact your broker, agent, or insurance carrier if you believe you are eligible for a NYSPHAP credit.

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium $
Insurance Company	Countersigned by_____	

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 31 06 18 (A)

POLICY NUMBER: UB-1T152983-25-14-G

NEW YORK WORKERS' COMPENSATION POLICYHOLDER NOTICE OF RIGHT TO APPEAL

Policyholder Disputes

Policyholders are entitled to inquire, challenge and dispute issues relating to classification, ownership, premium auditing and/or other New York Compensation Insurance Rating Board ("Rating Board") rulings or decisions pertaining to this policy. Please refer to the New York Workers' Compensation Policyholder Notice of Right to Appeal process noted below.

Inquiries may also be directed to the New York State Department of Financial Services (DFS) at:
http://www.dfs.ny.gov/about/contactus.htm#consumer
or by calling the Consumer Hotline at 800-342-3736 (Monday through Friday, 8:30 AM to 4:30 PM).

New York Workers' Compensation Policyholder Notice of Right to Appeal Process

An insured, or its representative, (hereafter referred to as "insured") may appeal the application of a rule or procedure contained in the New York Workers' Compensation & Employers' Liability Manual. Rules or procedures are defined as those determinations, either by a carrier or the Rating Board, which define the variables which make up, the policy conditions. Examples include: classification codes, ownership information, premium audits, and any other determination which may affect the policy.

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

1. The Rating Board will review the request and respond to the parties within sixty (60) days, either granting the parties or their authorized representatives their request or sustaining the Rating Board's original ruling.

2. If not satisfied with the outcome of 1. above, the parties may then request, in writing, a conference with members of the Rating Board staff. The request must state the nature of the complaint and supply any supporting documents. The appropriate Department Vice President or his or her designated representative will preside at the conference.

3. If the dispute is not resolved by the conference, the parties may then appeal to the Underwriting Committee of the Rating Board for a hearing to consider the staff ruling. This appeal must be in writing and must specify the reasons for the appeal and the nature of the complaint.

Following the Committee's receipt of the appeal request, the parties will be notified about the time and place for the hearing. The appeal will be heard at the next Underwriting Committee meeting for which appropriate time can be devoted to the matter.

After the hearing, the parties will be advised, in writing, of the Underwriting Committee decision on the complaint.

4. If the Underwriting Committee ruling is not satisfactory to either party, then the aggrieved party may request a hearing at the New York State Department of Financial Services to consider the disputed decision.

5. The decision of the New York State Department of Financial Services may be appealed to a court of law, by the parties involved or the Rating Board.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is replaced by the following condition:

D. Cancellation

1. You may cancel this policy. You must mail or deliver to us not less than 30 days advance notice stating when the cancellation is to take effect. Cancellation of coverage will be effective at 12:01 a.m. thirty (30) days after the date the cancellation notice is received by us, unless a later date is specified in the notice to us. You may cancel this policy effective less than 30 days after written notice is received by us where you have obtained other coverage or have become a self- insurer.

2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.

a. At any time during the policy period, we may cancel for nonpayment of premium. If we cancel for nonpayment of premium, we will mail notice of cancellation to you and to the Workers Compensation Commission at least 10 days before the cancellation is to take effect.

b. If we cancel this policy for a reason other than nonpayment of premium, we will mail notice of cancellation to you and to the Workers Compensation Commission at least 30 days before the cancellation is to take effect.

c. If this policy has been in effect for more than 45 business days or is a renewal policy, we may cancel for only one or more of the following reasons:

(1) Nonpayment of premium;

(2) Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted under it;

(3) Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;

(4) The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;

(5) A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;

(6) A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;

(7) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or

(8) Loss of or substantial changes in applicable reinsurance.

3. Mailing notice of cancellation to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

4. The policy period will end on the day and hour stated in the cancellation notice.

5. Any of these provisions that conflict with a law that controls the cancellation of the insurance inthis policy is changed by this statement to comply with the law.

Part 6 (Conditions) of the policy is amended by adding the following provisions:

F. Nonrenewal

1. If we elect not to renew this policy, we will mail or deliver written notice of nonrenewal to you at least 45 days before:

a. The expiration date of this policy; or

b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

2. Any notice of nonrenewal will be mailed or delivered to you at the mailing address shown in Item 1 of the Information Page. If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.

b. Proof of mailing will be sufficient proof of notice.

3. If notice of nonrenewal is not mailed or delivered at least 45 days before the expiration date or an anniversary date of this policy, coverage will remain in effect until 45 days after notice is given. Earned premium for such extended period of coverage will be calculated pro rata based on the rates applicable to the expiring policy.

4. We will not provide notice of nonrenewal if:

a. We, or another company within the same insurance group, have offered to issue a renewal policy; or

b. You have obtained replacement coverage or have agreed in writing to obtain replacement coverage.

5. If we have provided the required notice of nonrenewal as described above, and thereafter extend the policy for a period of 90 days or less, we will not provide an additional nonrenewal notice with respect to the period of extension.

G. Notice of Premium or Coverage Changes Upon Renewal

1. If we elect to renew this policy, we will give written notice of any premium increase, change in deductible, or reduction in limits or coverage, to you, at the mailing address shown in Item 1 of the Information Page.

2. Any such notice will be mailed or delivered to you at least 45 days before:

a. The expiration date of this policy; or

b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

3. If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.

b. Proof of mailing will be sufficient proof of notice.

4. If you accept the renewal, the premium increase or deductible, limits or coverage changes will be effective the day following the prior policy's expiration or anniversary date.

5. If notice is not mailed or delivered at least 45 days before the expiration date or anniversary date of this policy, the premium, deductible, limits and coverage in effect prior to the changes will remain in effect until the earlier of:

a. 45 days after notice is given; or

b. The effective date of replacement coverage obtained by you.

6. If you then elect not to renew, any earned premium for the resulting extended period of coverage will be calculated pro rata at the lower of the new rates or rates applicable to the expiring policy.

7. We will not provide notice of the following:

a. Changes in a rate or plan filed with or approved by the Insurance Commissioner or filed pursuant to the Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business; or

b. Changes based upon the altered nature of extent of the risk insured; or

c. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 35 06 03 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

OKLAHOMA FRAUD WARNING ENDORSEMENT

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

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 36 06 01 (E)

POLICY NUMBER: **UB-1T152983-25-14-G**

OREGON CANCELLATION ENDORSEMENT

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

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

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us, starting when the cancellation is to take effect. If you provide for other insurance or self-insurance, your cancellation of coverage will take effect upon the effective date of that insurance.

2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.

a. If we cancel based on our decision not to offer insurance to all employers with in your premium category, we will mail the notice of cancellation at least 90 days before the cancellation is to take effect.

b. If we cancel for other reasons, we will mail the notice of cancellation at least 45 days before the cancellation is to take effect.

c. If we cancel for nonpayment, we will mail notice of cancellation at least 10 days before the cancellation to take effect.

3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.

4. The policy period will end at 12 midnight on the day stated in the cancellation notice.

5. When coverage is placed with another carrier as of the policy expiration date, a rejected renewal policy shall be withdrawn without charge, provided notice of nonrenewal is mailed and postmarked on or before the expiration date and is received from the insured by the insurer no later than 10 calendar days after said expiration date.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: **01-08-25** ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: **UB-1T152983-25-14-G**

RHODE ISLAND SHORT RATE CANCELLATION ENDORSEMENT

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

The cancellation condition in the Workers Compensation and Employers Liability Insurance Policy – Part Five Premium, E. Final Premium, states that if this policy is cancelled by you, the final premium will be more than pro rata but not less than the policy minimum premium.

The final premium will be calculated as follows based on the Short-Rate Cancellation Table attached to this endorsement:

If	Then
This policy is cancelled by you, except when retiring from this business	Unless a different method has been filed by the carrier and approved by the appropriate regulatory authority, the premium for the cancelled policy must be calculated by using either the short-rate **percentage** or short-rate **factor** as follows, based on the Short Rate Cancellation Table located in Appendix B: Steps based on short-rate percentage: **1.** Determine the payroll developed during the period the policy was in effect. **2.** Determine the full policy payroll by using the following formula: $\frac{\text{number of days for which the policy was written}}{\text{number of days the policy was in effect}} \times \text{actual payroll}$ **3.** Apply authorized rates to such payroll. **4.** Calculate the extended number of days by using the following formula. If the policy was written for a one-year period, the extended number of days is the number of days the policy was in effect: $\frac{\text{number of days the policy was in effect}}{\text{number of days for which the policy was written}} \times 365$ **5.** Based on the extended number of days, apply the short-rate **percentage** shown in the **Short Rate Cancellation Table** located in the Appendix to the full policy premium calculated in step 3. This result is the short-rate manual premium. **6.** If applicable: • Apply any pricing programs • Apply any experience rating modification • Apply any premium discount based on the final earned total standard premium • Add the short-rate portion of the expense constant but not less than $15 • Apply catastrophe provisions based on the earned manual premium

	7. The total earned premium for the short-rate cancelled policy must not be less than the annual minimum premium applicable to the policy. Steps based on the short-rate **factor**: **1.** Determine the payroll developed during the period that the policy was in effect. **2.** Apply authorized rates to such payroll. **3.** Based on the number of days that the policy was in effect, determine the applicable short-rate **factor** shown in the **Short Rate Cancellation Table** located in Appendix B. **4.** Apply the short-rate factor to the premium calculated on the basis of the earned premium for the period that the policy was in effect in step 2. This result is the short-rate manual premium. **5.** If applicable: • Apply any pricing programs • Apply any experience rating modification • Apply any premium discount based on the final earned total standard premium • Add the short-rate portion of the expense constant but not less than $15 • Apply catastrophe provisions based on the earned manual premium **6.** The total earned premium for the short-rate cancelled policy must not be less than the annual minimum premium applicable to the policy.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 38 04 01 (B)

POLICY NUMBER: UB-1T152983-25-14-G

SHORT RATE CANCELLATION TABLE

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	303	87%	1.0396	335	94%	1.0242
272	80	1.0735	304	87	1.0480	336	94	1.0211
273	80	1.0696	305	87	1.0446	337	94	1.0181
274	81	1.0790	306	88	1.0411	338	95	1.0259
275	81	1.0751	307	88	1.0497	339	95	1.0229
276	81	1.0712	308	88	1.0462	340	95	1.0198
277	81	1.0673	309	88	1.0429	341	95	1.0169
278	81	1.0635	310	88	1.0395	342	95	1.0139
279	82	1.0728	311	89	1.0361	343	96	1.0216
280	82	1.0689	312	89	1.0445	344	96	1.0186
281	82	1.0651	313	89	1.0412	345	96	1.0156
282	82	1.0614	314	89	1.0379	346	96	1.0127
283	83	1.0705	315	90	1.0346	347	97	1.0203
284	83	1.0667	316	90	1.0429	348	97	1.0174
285	83	1.0630	317	90	1.0363	349	97	1.0145
286	83	1.0593	318	90	1.0330	350	97	1.0116
287	83	1.0556	319	90	1.0298	351	97	1.0087
288	84	1.0646	320	91	1.0380	352	98	1.0162
289	84	1.0609	321	91	1.0347	353	98	1.0133
290	84	1.0572	322	91	1.0315	354	98	1.0105
291	84	1.0536	323	91	1.0283	355	98	1.0076
292	85	1.0625	324	92	1.0364	356	99	1.0150
293	85	1.0589	325	92	1.0332	357	99	1.0122
294	85	1.0553	326	92	1.0301	358	99	1.0094
295	85	1.0517	327	92	1.0269	359	99	1.0065
296	85	1.0481	328	92	1.0238	360	99	1.0038
297	86	1.0569	329	93	1.0318	361	100	1.0111
298	86	1.0534	330	93	1.0286	362	100	1.0083
299	86	1.0498	331	93	1.0255	363	100	1.0055
300	86	1.0463	332	93	1.0224	364	100	1.0027
301	86	1.0429	333	94	1.0303	365	100	1.0000
302	87	1.0515	334	94	1.0272			

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 38 06 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

RHODE ISLAND DIRECT LIABILITY STATUTE ENDORSEMENT

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

1. Your employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.

2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of your employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct liability statute (Section 28.36.11) of the Rhode Island workers compensation law.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 38 06 02 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

RHODE ISLAND SAFETY INSPECTION ENDORSEMENT

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

If you pay an annual premium of more than twenty-five thousand dollars ($25,000) for workers compensation insurance, you may request that we inspect your site or sites of employment. You must make this request in writing. Inspection will be made within sixty days following receipt of your request. We will make a written report to you for your use in enhancing the safety and health of your employees on the site or sites inspected.

If your workers compensation premiums are less than fifty thousand dollars ($50,000) or your experience modification is less than 1.5 you may request one (1) inspection per calender year. You may be entitled to two (2) such inspections in one (1) calender year.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 39 06 01 (00)

POLICY NUMBER: UB-1T152983-25-14-G

South Carolina Cancellation and Nonrenewal Endorsement

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

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

D. **Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy by mailing or delivering to you, your agent, if any, and the South Carolina Workers' Compensation Commission written notice of cancellation at least
   a. 10 days before the effective date of cancellation, if we cancel for nonpayment of premium, or
   b. 30 days before the effective date of cancellation, if we cancel for any other reason.
3. We will mail or deliver our notice to you and your agent, if any, at their addresses shown in the Information Page or, if not shown on the Information Page, at their last known addresses. If notice is mailed, proof of mailing is sufficient proof of notice.
4. Any notice of cancellation will state the precise reason for cancellation.
5. If this policy has been in effect for 120 days or more, or is a renewal of a policy we issued, we may cancel this policy only for one or more of the following reasons:
   a. Nonpayment of premium.
   b. Material misrepresentation of fact which, if known to us, would have caused us not to issue the policy.
   c. Substantial change in the risk assumed, except to the extent that
      (1) we had notice of the change in risk prior to the expiration of the 120-day underwriting period, or
      (2) we should have reasonably foreseen the change or contemplated the risk when writing the policy.
   d. Substantial breaches of contractual duties, conditions, or warranties.
   e. Loss of our reinsurance covering all or a significant portion of the particular policy insured, or where continuation of the policy would imperil our solvency or place us in violation of South Carolina insurance laws. Prior to cancellation for reasons permitted in this Paragraph e., we will notify the director or their designee, in writing, at least 60 days prior to such cancellation and the director or their designee will, within 30 days of such notification, approve or disapprove such action.
6. The policy period will end on the day and hour stated in the cancellation notice.
7. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

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

F. **Nonrenewal**

1. If the renewal has been guaranteed by additional premium consideration, we will not refuse to renew a policy issued for a term of more than one year until expiration of its full term.

2. If we decide not to renew this policy, we will mail or deliver to you and your agent, if any, written notice of nonrenewal
   a. 60 days before the expiration date of this policy, if the policy is written for a term of one year or less, or
   b. 60 days before the anniversary date of this policy, if the policy is written for a term of more than one year or for an indefinite term.
3. We will mail or deliver our notice to you and your agent, if any, at their addresses shown on the Information Page or, if not shown on the Information Page, at their last known addresses. If notice is mailed, proof of mailing is sufficient proof of notice.
4. Any notice of nonrenewal will state the precise reason for nonrenewal.

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured		Premium $
Insurance Company	Countersigned by_____	

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

ENDORSEMENT WC 42 03 01 (L)

POLICY NUMBER: UB-1T152983-25-14-G

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

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

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

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

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

PART ONE – WORKERS COMPENSATION INSURANCE

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

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

F. **Payments You Must Make**

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

H. **Statutory Provisions**

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

PART TWO – EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

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

Section 6 is amended to read:

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

D. **We Will Defend**

This Section is amended by deleting the last sentence.

PART FOUR – YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

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

PART FIVE – PREMIUM

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

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

C. **Remuneration**

Number 2 is amended to read:

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

D. **Premium Payments** is amended by adding this sentence:

The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

E. **Final Premium**

Number 2 is amended to read:

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

PART SIX – CONDITIONS

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

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

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

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

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

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancelation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Department of Insurance – Division of Workers' Compensation.
3. Notice of cancelation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancelation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancelation or nonrenewal becomes effective if we cancel or do not renew because of:
   a. Fraud in obtaining coverage;
   b. Misrepresentation of the amount of payroll for purposes of premium calculation;
   c. Failure to pay a premium when payment was due;

d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;

e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.

4. If another insurance company notifies the Texas Department of Insurance – Division of Workers' Compensation that it is insuring you as an employer, such notice must be a cancelation of this policy effective when the other policy starts.

Add the following to the policy:

PART SEVEN – OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. **Claims Notification**

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

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

COMPLAINT NOTICE:

DISPUTE RESOLUTION SERVICES

NCCI'S DISPUTE RESOLUTION PROCESS DOES NOT APPLY TO WORKERS COMPENSATION CLAIMS.

For workers compensation claim disputes, see "CLAIM COMPLAINT" below. For issues related to a violation of law related to your policy, see "VIOLATIONS OF LAW" below.

Important Note: The dispute resolution services provided through the Dispute Resolution Process (Process) of the National Council on Compensation Insurance (NCCI) are **voluntary**. The Process is not an administrative remedy that must be exhausted before you pursue relief in court. Using the Process does not prevent you or the carrier that issued the policy from pursuing any available legal remedies at any time.

NCCI can assist in the resolution of a dispute regarding your policy that is related to any of the following matters:

- The application or interpretation of rules contained in the various (NCCI) manuals (including, but not limited to, classification codes and experience rating modifications)
- Rating programs
- Endorsements
- Forms

Contact the carrier that issued the policy and attempt to resolve the dispute directly. If you and the carrier cannot agree, then contact NCCI to ask for assistance. NCCI's ***Basic Manual*** rule, Dispute Resolution Process, addresses disputes. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and after you have paid any undisputed premium due to the carrier

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

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

VIOLATIONS OF LAW:

If you believe there has been a violation of law related to your policy, file a complaint with the Texas Department of Insurance:

Phone: 1-800-252-3439 **Online:** tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov **Mail:** MC CO-CP, PO Box 12030, Austin, TX 78711-2030

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance—Division of Workers' Compensation, Compliance and Investigations by mail to MC: CI, PO Box 12050, Austin, TX 78711-2050; or by fax to 512-490-1030; or by email to DWCCOMPLAINTS@tdi.texas.gov.

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 44 06 01 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

VERMONT LAW ENDORSEMENT

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

1. We may not limit our liability to pay damages if a judgment for damages is entered against you and we continue the suit or other action without your consent.

2. No action will lie against us to recover for a loss under this insurance unless it is brought within one year after the amount of loss is made certain either by agreement between the parties with our consent or by actual trial and final judgment. If you are bankrupt or insolvent, anyone who obtains such a judgment or agreement has a right of action against us to recover under the policy to the extent that insurance is provided for the damages or loss.

3. If you pay a judicial judgment or claim for any of our liability under this insurance, that will not bar you from an action or right of action against us.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 44 06 02 (C)

POLICY NUMBER: UB-1T152983-25-14-G

VERMONT CANCELLATION AND NONRENEWAL ENDORSEMENT

This endorsement applies because Vermont 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 this policy. We must provide to you by certified mail, and file with the Commissioner of Labor (Commissioner) or their designee as provided by Vt. Admin. Code 13-4-1:24.0000, at least 45 days' advance written notice stating when the cancellation is to take effect. Mailing notice by certified mail 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.

4. We may elect not to renew the policy. We must provide to you by certified mail, and give notice to the Commissioner or their designee as provided by Vt. Admin. Code 13-4-1:24.0000, at least 45 days' advance written notice stating when the nonrenewal is to take effect. If we do not give 45 days' notice, the policy will automatically be extended for 45 days from the date the notice is received by you and the Commissioner.

5. In the following circumstances, notice of nonrenewal to you is not required, and the policy will expire upon notice to the Commissioner or their designee as provided by Vt. Admin. Code 13-4-1:24.0000:

- **a.** We offer to continue the insurance by delivery of a renewal contract to you, or
- **b.** You notify us in writing that you do not want to renew the policy, or
- **c.** You obtain other insurance or a guarantee contract, or you establish and maintain, to the satisfaction of the Commissioner, security for compensation.

6. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

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

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 45 06 02 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

VIRGINIA AMENDATORY ENDORSEMENT

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

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

1. You may cancel this policy. You must mail or deliver advance written notice to us. You must provide written notice of your cancelation, including the date of and reasons for the cancelation, to the Workers Compensation Commission.

2. We may cancel this policy. We will provide you with 30 days notice of cancelation. We will provide the Workers Compensation Commission with immediate notice of such cancelation. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

3. In the event of cancelation by you or us, you must provide 30 days written notice of the cancelation to your covered employees.

4. We may nonrenew your policy. We will provide 30 days notice to you and to the Workers Compensation Commission of our decision to nonrenew. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

5. If you fail to pay the premium due on this policy we may cancel the policy by providing 10 days notice to you and to the Workers Compensation Commission.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 47 06 01 (00)

POLICY NUMBER: UB-1T152983-25-14-G

WEST VIRGINIA CANCELLATION ENDORSEMENT

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

Part Six, D (Conditions – Cancellation) is replaced by:

D. Cancellation

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

2. We may cancel this policy at any time by providing you thirty (30) days advance written notice.

3. Not withstanding #2 above, if you fail to pay any premium due or refuse to comply with a premium audit under this policy, we may cancel the policy by providing you ten (10) days advance written notice.

4. We may also choose not to renew this policy by providing sixty (60) days advance written notice.

5. Our mailing of the Notice of Cancellation or Non-Renewal to your mailing address as listed in Item 1 of the information page will be sufficient notice of our intent to cancel. We will also provide notice of the cancellation or non-renewal of the policy to the West Virginia Insurance Commissioner at least ten (10) days prior to the effective date of the termination, within ten (10) days of receipt of your request for cancellation, as applicable.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 48 06 01 (C)

POLICY NUMBER: **UB-1T152983-25-14-G**

WISCONSIN LAW ENDORSEMENT

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

II. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all the terms of this policy.

IV. If any injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: **UB-1T152983-25-14-G**

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect. If you purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.

2. We may cancel this policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:

a. you fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;

b. a material misrepresentation;

c. a substantial breach of the obligations, conditions or warranties under the policy; or

d. a substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.

3. If we cancel for any permissible reason other than non-payment of premium, we must deliver or mail, first class, not less than* thirty (30) days notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than* sixty (60) days advance written notice stating our intention not to renew this policy.

2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.

3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year whichever is less.

4. If we offer to renew the policy on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policy holder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 48 06 06 (B)

POLICY NUMBER: **UB-1T152983-25-14-G**

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after written notice is mailed or delivered, in which case, you, the policy holder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and extent of the risk insured against, including, but not limited to, a change in the classifications for the business.

* Any written agreement attached to and made a part of the policy, between the insurance carrier and policyholder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 52 06 02 (15)

POLICY NUMBER: UB-1T152983-25-14-G

HAWAII NOTIFICATION ENDORSEMENT

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

Hawaii law requires that all policies issued to employers for workers compensation insurance disclose clearly to employers as separate figures the portion of the premium charged for categories (1) through (5) below. Category (6) is provided for informational purposes only so that the figures total 100% in Column A. These figures are provided below in column A as percentages of standard premium because rates are filed and approved on a standard premium basis. If the figures were not provided as percentages of standard premium, the percentages would vary by policy based on any premium discounts applied to the individual policy. Hawaii law also requires the disclosure of the percentages of premiums expended during the previous year by the insurer for claims paid in the same categories. These percentages are provided below in Column B based on the most recent available calendar year data. The figures in Column B may not total to 100% since premiums collected in any individual calendar year will not correspond exactly to the claims and expenses paid in that calendar year.

Category	A	B
(1) Medical care, services, and supplies	27.4%	-27.7%
(2) Wage loss benefits including temporary total, temporary partial, and permanent total disability benefits and their related benefits	14.2%	-14.4%
(3) Indemnity benefits for permanent partial disability	15.0%	-15.1%
(4) Death benefits	0.3%	-0.3%
(5) Loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations and private investigation costs	11.5%	-8.8%
(6) Production costs, general expense, premium tax, Special Compensation Fund, miscellaneous tax, Hawaii Hurricane Relief Fund	31.6%	26.0%

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 54 06 01 (A)

POLICY NUMBER: **UB-1T152983-25-14-G**

ALASKA NOTICE OF INSTALLMENT OPTION ENDORSEMENT

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

If your annual estimated premium exceeds $2,000, you may elect to pay your premium on an installment basis of not fewer than two payments. Premiums paid by installment must be structured to reflect seasonal peaks in the basis of the premium.

If you elect to pay your premium on an installment basis, we will provide the installment schedule to you.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 54 06 02 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

ALASKA CANCELATION AND NONRENEWAL ENDORSEMENT

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

The Cancelation Condition, as well as Part Five, Paragraph E.2., of the policy is replaced by this Condition:

D. Cancelation/Nonrenewal

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect. If you cancel, the final premium will be calculated pro rata based on the time the policy was in force, and increased by a cancelation fee equal to 7.5 percent of the unearned premium, provided that the final premium will not be less than the applicable minimum premium.

2. We may cancel this policy. We must mail or deliver to you and the agent or broker of record advance written notice stating the reason for cancelation and when the cancelation is to take effect. Such notice will be mailed or delivered not less than:

a. 10 days before the effective date of cancelation if we cancel for conviction of the insured of a crime having as one of its necessary elements an act increasing a hazard insured against, or for discovery of fraud or material misrepresentation made by the insured or a representative of the insured in obtaining the insurance or by the insured in pursuing a claim under the policy; or

b. 20 days before the effective date of cancelation if we cancel for nonpayment of premium, or for failure or refusal of the insured to provide the information necessary to confirm exposure or determine the policy premium; or

c. 60 days before the effective date of cancelation if we cancel for any other reason.

3. We will mail or deliver the notice to your last known address and the last known address of the agent or broker of record.

4. A post office certificate of mailing or certified mailing receipt will be sufficient to prove notice.

5. The policy period will end on the day and hour stated in the cancelation notice.

6. If we decide not to renew this policy, we will mail written notice of nonrenewal, by first class mail, to you and the agent or broker of record at least 45 days before:

a. the expiration date; or

b. the anniversary date if this policy has been written for more than one year or with no fixed expiration date.

7. We need not mail notice of nonrenewal if:

a. we have manifested in good faith our willingness to renew; or

b. you have failed to pay any premium required for this policy; or

c. you fail to pay the premium required for renewal of this policy.

8. Any notice of nonrenewal will be mailed to your last known address and the last known address of the agent or broker of record. A post office certificate of mailing or certified mailing receipt will be sufficient proof of notice.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 06 46 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

ILLINOIS AMENDATORY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Illinois is shown in Item 3.A. of the Information Page. Exclusion C., 1., of Part Two (Employers Liability) of the policy is replaced by the following:

C. Exclusions

1. is replaced by:

1. liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner.

This exclusion also does not apply to your liability to a third party by reason of a claim or suit against you by that third party for contribution under the Illinois Joint Tortfeasor Contribution Act for damages claimed against such third party as a result of injury to your employee if such liability is otherwise covered under this Part Two of the policy, and you have that liability because you have waived, in a written contract, your right to limit such liability to the amount of the workers compensation benefits paid for that injured employee under the Illinois Workers Compensation Act. This exception only applies to bodily injury by accident that occurs after that contract was made and to bodily injury by disease caused or aggravated by conditions to which the injured employee's last day of exposure occurs after that contract was made.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY INFORMATION PAGE – OKLAHOMA AMENDATORY ENDORSEMENT

This form amends item 2 of the Workers Compensation and Employers Liability Policy Information Page to clarify that policy period is effective 12:01 A.M. standard time at the insured's mailing address.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

DATE OF ISSUE: 01-08-25 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 99 06 T1 (00) - 001

POLICY NUMBER: UB-1T152983-25-14-G

NEW YORK NOTICE OF CANCELLATION TO DESIGNATED GOVERNMENTAL ENTITIES

This endorsement applies to the insurance provided by the policy because New York Workers' Compensation Board Form C-105.2 was provided to the governmental entity designated in the Schedule below as proof of this insurance.

The following is added to **PART SIX – CONDITIONS**:

Notice Of Cancellation To Designated Governmental Entities

If we cancel this policy for any reason other than non-payment of premium by you, we will mail or deliver notice of such cancellation to each governmental entity designated in the Schedule below within thirty days of the cancellation's effective date.

If we cancel this policy for non-payment of premium by you, we will mail or deliver notice of such cancellation to each governmental entity designated in the Schedule below within ten days of the cancellation's effective date.

You are responsible for providing us with the information necessary to accurately complete the Schedule below. If we cannot mail or deliver a notice of cancellation to a designated governmental entity because the name or address of such designated governmental entity provided to us is not accurate or complete, we have no responsibility to mail, deliver or otherwise notify such designated gov ernmental entity of the cancellation.

Failure to provide such notice to the governmental entity designated in the Schedule below will not amend or extend the date the cancellation becomes effective, nor will it negate cancellation of the policy.

SCHEDULE

Name and Address of Designated Government Entities:

NYSED
89 WASHINGTON AVE.
ALBANY NY 11373

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

ST ASSIGN:

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 17 03 03 (00)

POLICY NUMBER: **UB-1T152983-25-14-G**

LOUISIANA DUTY TO DEFEND ENDORSEMENT

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

The duty to defend provisions of the policy is replaced by this provision.

Part Two – Employer's Liability

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.

Our duty to defend ends when the limit of liability has been exhausted by the payment of a judgment or settlement.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR NEW YORK WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

This medical and indemnity deductible program is being offered to policyholders with an estimated annual premium at inception of twelve thousand dollars or more. Under this deductible program we pay all amounts in their entirety applicable to each compensable claim under Part One of the policy.

We then obtain reimbursement from you, the policyholder, subject to the limits of the deductible amount for each occurrence. You are liable to us for the deductible amount in regard to benefits paid for compensable claims, and failure by you to reimburse any deductible amounts to us shall be treated in the same manner as nonpayment of premium.

The deductibles paid by you during any one year period of insurance shall not exceed the estimated annual premium at inception for such policy of insurance. A policy written under this deductible program shall have attached the New York Benefits Deductible Endorsement WC 31 03 15 (A) to the policy. One of the following deductible amounts, per occurrence, is available for selection by you to activate this program.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days from the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your agent.

DEDUCTIBLE TABLE

DEDUCTIBLE PER OCCURRENCE:	
$ 100	$1,000
$ 200	$1,500
$ 300	$2,000
$ 400	$2,500
$ 500	$5,000

DATE OF ISSUE: **01-08-25**

YES, I WANT A DEDUCTIBLE OF $ _____ APPLIED TO MEDICAL AND INDEMNITY BENEFITS UNDER THE NEW YORK WORKERS COMPENSATION LAW. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with New York law, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below .

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR COLORADO WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

Colorado Policyholders

Colorado law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each claim for bodily injury by accident or disease. The deductible amount is subject to a minimum of $500 and a maximum of $18,500 as shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, WC 00 06 03(00), will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available please contact your producer.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL BENEFITS

$500, $1,000, $1,500, $2,000, $2,500, $5,000, $10,000, $13,500, $14,500, $15,500, $16,000, $16,500, $17,000, $17,500, $18,000 or $18,500.

Yes, I want a deductible of $ _____ applied as indicated above under the Colorado Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date:_____

Employer:_____

Name:_____

Title:_____

Signature:_____

Insurance Company:_____

DATE OF ISSUE: 01-08-25

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR ALABAMA WORKERS' COMPENSATION MEDICAL AND INDEMNITY BENEFITS

Alabama Policyholders

Alabama law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $2,500 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, WC 00 06 03 (00), will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your producer.

TABLE

Workers Compensation
Available Deductibles Per Accident: $100, $200, $300, $400, $500, $1,000, $1,500, $2,000 or $2,500.

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Alabama Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Alabama revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer's Name: _____

Policy Number: _____

DATE OF ISSUE: 01-08-25

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR DELAWARE WORKERS' COMPENSATION DEATH AND MEDICAL BENEFITS

Delaware Policyholders

Delaware law permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for death and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $500 and a maximum of $5,000 for each accident, with intermediate increments of $500 as shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain a copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing this option, please contact your producer.

DEDUCTIBLE PER ACCIDENT	PERCENT PREMIUM REDUCTION	DEDUCTIBLE PER ACCIDENT	PERCENT PREMIUM REDUCTION
$ 500	1.1%	$ 3,000	3.9%
1,000	1.9	3,500	4.3
1,500	2.5	4,000	4.7
2,000	3.1	4,500	5.0
2,500	3.5	5,000	5.3

Yes, I want a deductible of $ _____applied to my medical and indemnity benefits under the Delaware Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Volume 63, Chapter 250, Delaware Laws, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

DATE OF ISSUE: 01-08-25

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF ELECTION TO ACCEPT A BENEFIT DEDUCTIBLE AND/OR COINSURANCE PROGRAM FOR WORKERS' COMPENSATION COVERAGE IN FLORIDA

Florida Policyholders

The Florida law now permits an employer to buy Workers' Compensation Insurance with a deductible coinsurance or in a deductible coinsurance combined option. The program is applied to indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum and a maximum for each accident, depending which program is selected.

Effective January 1, 1994 the State of Florida passed in special session a $2,500 State Authorized deductible. Any amount paid by the employer in this deductible option (4) shall reduce the amount of loss that goes into Experiencing Rating of such employer. There is no premium credit applied to this program.

To prevent putting you in an uninsured position, your policy has been issued at full rates without this program being applied.

If you wish to have one of the options apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want this benefit deductible and/or coinsurance program to apply, or if you already have it on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing one of these options, please contact your agent.

DATE OF ISSUE: **01-08-25**

Item #1: PROGRAM _____

AMOUNT _____

Item #2:

Program 1 - Coinsurance/Deductibles		Program 2 - Coinsurance	
Deductible Amount w/$21,000 Coinsurance	Policy Premium Reduction	Coinsurance Amount	Policy Premium Reduction
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker	$ 5,000 10,000 15,000 20,000 21,000	See Your Agent/ Broker
Use Florida Coinsurance and Deductible Endorsement WC 09 06 03.		Use Florida Deductible Endorsement WC 09 06 04.	
Program 3 - Deductibles		**Program 4 - Deductible**	
Deductible Amount	Policy Premium Reduction	Deductible $2,500 (No Policy Premium Credit)	
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker		
Use Florida Benefits Deductible Endorsement WC 09 06 05.		Use Florida Benefits Deductible Endorsement WC 09 06 05.	

Yes, I want the program/amount that I selected in Item #1 to be applied to my policy for medical and indemnity benefits under the Florida Workers' Compensation Law. I understand that the company shall pay the deductible or coinsurance amount and seek reimbursement from the employer shown below.

I understand that in accordance with Florida Laws, I have the option of modifying the above program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____ Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

DATE OF ISSUE: **01-08-25**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR GEORGIA WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

Georgia Policyholders

Georgia law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $2,500 for each accident, with intermediate increments as shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Three copies of this form are provided: (1) Retain a copy for your records; (2) Send a copy to your producer to keep him/her informed of your intention; and (3) Complete and return a copy to the carrier at the service address noted above within sixty (60) days after the effective date of your policy. An endorsement, will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your producer.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL DEDUCTIBLE PER ACCIDENT:	$100, $200, $300, $400, $500, $1,000, $1,500, $2,000 or $2,500

Yes, I want a deductible of $_____ applied to medical and benefits under the Georgia Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Georgia Law I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: THE TRAVELERS INSURANCE COMPANIES

DATE OF ISSUE: 01-08-25

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR ILLINOIS WORKERS' COMPENSATION MEDICAL BENEFITS

Illinois Policyholders

Illinois law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical benefits only and applies separately to each accident, regardless of the number of people who sustain injury by such accident. The deductible amount is $1,000 for each accident.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement, will be then attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a medical deductible on the policy, you may disregard this form. Your policy will continue in force as issued. For a complete explanation of how this program operates or the savings available by choosing this option, please contact your agent.

Yes, I want a deductible of $1,000 applied to medical benefits under the Illinois Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

Date: _____ Employer: _____

Name: _____

Title: _____

Insurance Company: _____

DATE OF ISSUE: **01-08-25**

W12N3C01

Illinois

Preferred Provider Program

Inside:

- Employer Information and Implementation Guideline
- Employee Notice of Workers' Compensation Preferred Provider Program
- Notice of Preferred Provider Program for Workers' Compensation Medical Care
- Preferred Provider Program Key Points
- How to Find a Network Provider

Employer Information and Implementation Guideline

Welcome to the Preferred Provider Program (PPP) for Illinois. As an insured of Travelers, you are able to take an active role in helping reduce your workers' compensation costs. Travelers has partnered with Coventry Health Care Workers' Compensation, Inc. to provide a custom PPP that is approved in every county in the state of Illinois. The enclosed materials will explain how to implement and use this program for your employees' work-related injuries.

The PPP is a network of medical care providers designated for treatment of work-related injuries. The PPP is required to have an adequate choice of medical providers available to treat common injuries within a reasonable distance of a covered employee's residence. Participation in this PPP allows you to encourage your injured employees to choose medical providers from a listing of PPP providers. These PPP providers have experience treating work-related injuries. The PPP encourages a proactive approach toward diagnosing and treating work-related injuries and promoting a safe, medically appropriate return to work.

What you should know

- An injured employee is allowed two choices of treating provider.
- After being informed of the PPP, an employee has the right to decline participation in writing subsequent to and at any time after an injury occurs.
- If an employee declines to participate, this written notice constitutes one choice of provider, leaving him/her with only one more choice.
- You will need to retain and provide any written notices of non-participation that you receive to Travelers when an injury occurs.
- First aid or emergency care should be obtained from the nearest medical facility and does not constitute a choice of provider.

Implementation Steps

1. Provide your employees with a copy of the ***Notice of Worker's Compensation Preferred Provider Program (PPP)*** as directed by the Illinois Workers' Compensation Commission and included in this packet.
2. Determine and post at the worksite a listing of occupational clinics and treating doctors available in the network and nearby your worksite.
3. If a worksite injury occurs, encourage your participating employee to choose a treating doctor from the PPP network directory.
4. When you receive notice of an injury, provide your employee with a copy of the ***Notice of Preferred Provider Program for Workers' Compensation Medical Care*** found in this packet. This will reinforce the notice provided when the program was implemented.
5. Collect, retain and forward to Travelers any written notices of non-participation in the PPP.
6. Remember to report your claim to Travelers.

Please take some time to review the information on ***How to Find a Network Provider***. If you have any questions about this program and the enclosed materials, please contact us at 844 722-4698.

The Travelers Indemnity Company/Coventry Health Care Workers Compensation, Inc.

Notice of Our Workers' Compensation Preferred Provider Program (PPP)

This information is being provided to you to explain your rights and responsibilities should you have an accident at work.

Illinois law allows our company to offer healthcare services to employees for workers' compensation injuries through a Preferred Provider Program (PPP). The Illinois Department of Insurance has approved our network of medical providers for treatment of work related injuries. The Department of Insurance requires our PPP network to meet standards for geographic accessibility, adequacy of medical providers and other factors important to assuring the adequacy of care to our injured employees.

You may choose to be treated by any of the medical providers of your choice in our PPP subject to the limitations described below. Our list of PPP medical providers is attached or you may access the list of the medical providers in our PPP at www.Travelers.com/injuredemployee.

After your report of injury to us, you may in writing to us decline your participation in the PPP. Should you decline participation in the PPP, the law provides that your declination of participation constitutes one of the two choices of medical providers to which you are otherwise entitled. You may also decline treatment from our PPP at any time throughout your treatment for this work-related injury. However, that declination will also constitute one of your two choices of medical providers unless the Illinois Workers' Compensation Commission determines that the medical treatment provided to you by our PPP is inadequate.

In addition, the law provides if, prior to report of an injury, you are provided non-emergency treatment from a medical provider not within the PPP, that treatment would constitute one of the two choices of a medical provider to which you are otherwise entitled to. Please be advised that our company may not be required to pay for medical treatment you receive from medical providers outside or beyond your two choices of medical providers and subsequent referrals.

If our PPP does not provide a medical provider who can provide an approved medical treatment, a medical provider not a member of the PPP may be used at our expense if you have complied with our PPP's pre-authorization requirements for use of the medical provider who is not a member of the PPP.

For additional information regarding our program requirements, please review the attached materials that we are required to provide you pursuant to Section 370m (215 ILCS 5/370m) of the Illinois Insurance Code.

IF YOU ARE INJURED ON THE JOB, IN CASE OF EMERGENCY, SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST EMERGENCY FACILITY.

Immediately report your injury to your supervisor/manager or contact:

Employer: _____

Contact name: _____

Address: _____

Telephone: _____

The Travelers Indemnity Company/Coventry Health Care Workers Compensation, Inc.

NOTICE OF PREFERRED PROVIDER PROGRAM FOR WORKERS' COMPENSATION MEDICAL CARE

We have received your report of a work-related injury. Please be advised that we have established a Preferred Provider Program (PPP) for medical treatment for workers' compensation cases, pursuant to the Illinois Workers' Compensation Act (820 ILCS 305/8(a) and 8.1a). Our PPP has been approved by the Illinois Department of Insurance as required under the Act.

We recommend that you obtain your medical care from the PPP network for any work-related injury because we believe it will provide good treatment for you. You may decline to be treated by providers in our PPP now or at any time throughout your treatment for this work-related injury.

Such declination must be made to us in writing, and will count as one of your two choices of medical providers. We may not be required to pay for medical services outside or beyond your two choices of medical providers and the chain of referrals there from.

However, not receiving treatment from our PPP will not be considered a choice of physicians if: 1) there is no medical provider in the PPP that provides treatment you need and you comply with all pre-authorization requirements; or 2) the Illinois Workers' Compensation Commission has determined that the treatment provided to you by our PPP is inadequate.

To obtain the list of medical providers in the PPP, go to www.Travelers.com/injuredemployee or call (844)722-4698. To decline participation in the PPP, you must do so in writing; direct it to ILPPP@travelers.com. If you have questions about the employer's PPP network, please call 844-722-4698.

If you have any questions about your rights under the law, please call the Public Information Unit at the Illinois Workers' Compensation Commission at 312/814-6611, toll-free 866/352-3033, email the IWCC at infoquestions.wcc@illinois.gov, or check the Commission's website at www.iwcc.il.gov/.

The Travelers Indemnity Company/Coventry Health Care Workers Compensation, Inc.

Aviso de Nuestro Programa de Proveedor Preferido (PPP) de Compensación Laboral

Esta información se le provee para explicarle sus derechos y responsabilidades en caso de que usted tenga un accidente en su trabajo.

La ley de Illinois permite a nuestra compañía ofrecer servicios de atención médica a los empleados para lesiones relacionadas con Compensación Laboral, a través de un Programa de Proveedor Preferido (PPP). El Departamento de Seguros de Illinois ha aprobado nuestra red de proveedores de servicios médicos para el tratamiento de lesiones relacionadas con su trabajo. El Departamento de Seguros requiere que nuestra red PPP cumpla las normas de accesibilidad geográfica, competencia de los proveedores de servicios médicos y otros factores importantes para asegurar la aceptabilidad de la atención a nuestros empleados lesionados. Usted puede elegir recibir tratamiento por cualquiera de los proveedores de servicios médicos que usted elija en nuestro PPP sujetándose a las limitaciones descritas más abajo. Se adjunta nuestra lista de proveedores de servicios médicos del PPP, o usted puede acceder a esta lista de proveedores de servicios del PPP en www.Travelers.com/injuredemployee.

Después de habernos informado de su lesión, usted puede negarse a participar en el PPP comunicándonoslo por escrito. En caso de que usted rehúse participar en el PPP, la ley establece que su rechazo a la participación constituye una de las dos opciones de proveedores de servicios médicos a las que usted tendría derecho. Usted también puede negarse a recibir tratamiento de nuestro PPP en cualquier momento durante su tratamiento de esta lesión relacionada con su trabajo. No obstante, esta denegación también constituirá una de sus dos opciones de proveedores de servicios médicos, a menos que la Comisión de Compensación Laboral de Illinois determine que el tratamiento médico que le dio nuestro PPP fuera inadecuado. Además, la ley dispone que si antes de reportar una lesión usted recibe atención que no sea de emergencia de un proveedor de servicios médicos no perteneciente al PPP, ese tratamiento constituirá una de las dos opciones de proveedores de servicios médicos a las que usted tendría derecho. Por favor, tenga en cuenta que nuestra compañía no tiene obligación de pagar por tratamientos médicos que usted reciba fuera o más allá de sus dos elecciones de proveedores de servicios médicos y sus referencias subsiguientes.

Si nuestro PPP no tiene un proveedor de servicios médicos que pueda dar un tratamiento médico aprobado, podrá usarse un proveedor de servicios médicos no perteneciente a nuestro PPP con los gastos a nuestro cargo si usted ha cumplido con los requisitos de autorización previa de nuestro PPP para el uso del proveedor de servicios que no sea miembro de nuestro PPP.

Para obtener mayor información de los requisitos de nuestro programa, sírvase revisar los materiales adjuntos que se nos exige que le demos según la Sección 370m (215 ILCS 5/370m) Del Código de Seguros de Illinois.

SI SE LESIONA EN SU TRABAJO, EN CASO DE EMERGENCIA PROCURE ATENCIÓN MÉDICA INMEDIATA EN LA INSTITUCIÓN DE CUIDADOS DE EMERGENCIA MÁS CERCANA.

Reporte inmediatamente su lesión a su supervisor/gerente o comuníquese con:

Empleador: _____

Nombre del Contacto: _____

Dirección: _____

Teléfono: _____

The Travelers Indemnity Company/Coventry Health Care Workers Compensation, Inc.

AVISO DE PROGRAMA DE PROVEEDOR PREFERIDO PARA CUIDADOS MÉDICOS A TRAVÉS DE COMPENSACIÓN LABORAL

Ha recibido su informe de una lesión que usted sufrió en su trabajo. Sírvase tener en cuenta que hemos establecido un Programa de Proveedor Preferido (PPP) para tratamientos médicos en casos de Compensación Trabajadores, de acuerdo con lo dispuesto en la Ley de Compensación Trabajadores de Illinois (Illinois Workers' Compensation Act) (820 ILCS 305/8(a) y 8.1a). Nuestro PPP ha sido aprobado por el Departamento de Seguros de Illinois tal como lo requiere la Ley arriba citada.

Le recomienda obtener atención médica a través de la red PPP para cualquier lesión relacionada con su trabajo porque consideramos que le proveerá un buen tratamiento. Usted puede negarse a recibir tratamiento de los proveedores de nuestro PPP ahora o en cualquier momento durante su tratamiento por esta lesión relacionada con su trabajo.

Deberá comunicarnos por escrito si se niega, y se contará como una de sus dos elecciones de proveedores médicos. No se nos podrá exigir que paguemos por servicios médicos prestados fuera o más allá de sus dos elecciones de proveedores de servicios médicos y la cadena de referencias de los mismos.

No obstante, no recibir tratamiento a través de nuestro PPP no se considerará una elección de médicos si: 1) no hay un proveedor de servicios médicos en el PPP que ofrezca el tratamiento que usted necesita, y usted cumple con todos los requisitos de autorización previa; o 2) La Comisión de Compensación Trabajadores de Illinois ha determinado que el tratamiento que le ha prestado nuestro PPP es inadecuado.

Para obtener la lista de proveedores de servicios médicos en el PPP visite el sitio web: www.Travelers.com/injuredemployee o llame al (844) 722-4698. Para declinar su participación en el PPP, debe hacerlo por escrito; diríjalo a ILPPP@travelers.com. Si tiene preguntas acerca de la red del PPP del empleador, sírvase comunicarse con (844)722-4698.

Si tiene cualquier pregunta acerca de los derechos que le otorga la ley, llame por favor a la Unidad de Información pública de la Comisión de Compensación Trabajadores de Illinois al 312/814-6611, llame sin cargo al 866/352-3033, envíe un correo electrónico a IWCC a infoquestions.wcc@illinois.gov, o visite la página de Internet de la Comisión en www.iwcc.il.gov/.

Preferred Provider Program Key Points

- An injured employee is allowed to choose a treating provider from the network directory who is appropriate for the treatment of his or her occupational injury. The injured employee is allowed to make up to two choices of treating providers. Any additional change will require approval of the employer and/or Travelers.

- If an employee does not wish to participate in the PPP, the employee must provide notice in writing to the employer and Travelers should a work related injury occur.

- If participation has been declined in writing, it constitutes one of the available two choices of provider.

- First Aid or Emergency care should be given at the closest medical facility and does not constitute a provider choice.

- When an employee provides a notice of work-related injury to the employer, the employer may recommend the injured employee to choose a provider within the PPP network.

- Any non-emergency treatment with a non-PPP provider selected by the injured employee prior to giving notice of a work-related injury to the employer is considered to be one of the employee's choices of provider(s).

  Primary treating and hospital health care services for emergency medical must be located within 30 minutes or 15 miles of the employee's residence in a non-rural area.

- Occupational health services and specialty providers are to be within 60 minutes or 30 miles of the employee's residence.

- An appointment for initial treatment is to be available within three business days of a request.

- An appointment for treatment of common work-related injuries is to be available within twenty business days of request.

- If an employee is working or resides temporarily or permanently outside the Illinois geographic area, and requires treatment for their work-related injury, they may choose a treating provider from a network listing of at least three providers in that area.

- Employers and employees may obtain a current provider network listing by:

  - Searching in Claim Center and Find a Service Provider on www.Travelers.com/injuredemployee

  - Sending a request to ILPPP@travelers.com

  - Calling (844)722-4698 and requesting a listing

- Talking with the Claim Professional and requesting a listing

How to Find and Use the Network Directory

1. **Access the PPP Network directory by linking to www.Travelers.com/injuredemployee**
    - Select "Find a Service Provider" towards the bottom of the page.
    - Step 1, on the following page, defaults to "Medical Providers"
    - Step 2, Select the type of incident you had: "Workers Compensation"
    - Step 3, regarding ConciergeCLAIM Nurse location:
        - If "Yes" is selected, this will provide you with the name of the nearest ConciergeCLAIM Nurse location for the ZIP Code provided.
        - If "No" is selected, you will need to select Medical Provider Type(s) and ZIP Code.
    - Screen shows results that match search criteria. **ONLY IL PPP providers can be used.**

2. **You are now in the Workers Compensation provider database:**
    - Select – "Provider Search" located in the Red Toolbar located at the top of the screen to search for a provider near a specific location.
    - Enter city, state and/or zip code
    - "Network Selection"- **IL PPP must be selected**.
    - "Search Distance (miles)" – May change number of miles
    - May "Sort Results By": Distance – Name – Specialty

Continue:
- Select – provider type/specialty that is needed

Click Find Providers:
- Screen shows results that match criteria. To see more providers, click page hyperlink at the top or bottom of the page button to continue review of all providers found in your search.

Or:
- Select – "Provider Look Up" located in the Red Toolbar located at the top of the screen to search by provider name (enter provider name and zip code)

3. This site has other features such as a link to workers' compensation claim resources and information regarding how to obtain injury related medications prescribed by the treating provider.

4. Additional information about a provider can be obtained by clicking on the provider's name.

5. A selected listing may be printed or emailed to a recipient's email address.

6. Another method is to email a request for a listing to wcppn@travelers.com specifying a location or locations. Listings will be generated and provided by email in response.

7. If internet access is not available, please contact Travelers at 844-722-4698 and request a provider listing, which will be sent by mail within 3 business days.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR KENTUCKY WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

Kentucky Policyholders

Kentucky law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $10,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible for medical benefits.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement (WC 00 06 03 (00)) will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your agent.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL DEDUCTIBLE PER ACCIDENT:	$100	$200	$300	$400
	$500	$,1000	$1,500	$2,500
	$5,000	$7,500	$10,000	

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Kentucky Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Kentucky revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer's Name: _____

Policy Number: _____

DATE OF ISSUE: 01-08-25

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR MAINE WORKERS' COMPENSATION INDEMNITY BENEFITS OR MEDICAL EXPENSE ONLY BENEFITS

Maine Policyholders

Maine law now permits an employer to buy Workers' Compensation Insurance with a deductible. One deductible is for indemnity benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $1,000 and a maximum of $5,000 for each accident. The other deductible is for medical expense only and also applies separately to each accident during the policy term regardless of the number of employees who sustain injury in the accident. The deductible amount is either $250 or $500 for each accident or per occurrence (See Below).

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have a deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your agent.

INDEMNITY BENEFITS DEDUCTIBLE PER ACCIDENT	MEDICAL BENEFITS DEDUCTIBLE**
$1,000	$250
$5,000	$500

The Medical Benefits Deductible option is available as follows: **$250 to employers who are not Experienced Rated, insurers shall offer a deductible of $250 per accident for bodily injury or disease regardless of the number of people who sustain injury by such accident or disease. **$250 or $500** to employers who are Experience Rated, insurers shall offer a deductible of $250 or $500 per occurrence.

Yes, I want a deductible of $ _____ Indemnity Benefits and/or a deductible of $_____ Medical expense applied. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Maine Laws, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date:_____ Employer: _____

Name: _____

Title: _____

Insurance Company: _____

DATE OF ISSUE: 01-08-25

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR MINNESOTAWORKERS' COMPENSATION MEDICAL AND INDEMNITY BENEFITS

Minnesota Policyholders

Minnesota law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $50,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement, (WC 00 06 03 (00)) will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available, please contact your producer.

DEDUCTIBLE TABLE

MEDICAL DEDUCTIBLE	TOTAL CLAIM DEDUCTIBLE
$100	$100
$150	$150
$200	$200
$250	$250
$500	$500
$1,000	$1,000
$1,500	$1,500
$2,000	$2,000
$2,500	$2,500
$5,000	$5,000
$10,000	$10,000
$25,000	$25,000
$50,000	$50,000

Yes, I want a: – **Medical Deductible** _____ or **Total Claim Deductible** _____

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Minnesota Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Minnesota revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

DATE OF ISSUE: 01-08-25

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Agent's Name: _____

Policy Number: _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR NEW HAMPSHIRE WORKERS' COMPENSATION BENEFITS

New Hampshire Policyholders

New Hampshire law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is a per claim benefit deductible or a per accident or per disease deductible. The deductible amount is subject to a minimum of $500 and a maximum of $5,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible for medical benefits.

If you wish to have either deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available,please contact your agent.

DEDUCTIBLE TABLE

DEDUCTIBLE OPTION #1

Policy Premium Reduction Per Claim

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

DEDUCTIBLE OPTION #2

Policy Premium Reductions Per Accident or Disease

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

DATE OF ISSUE: 01-08-25

Yes, I want a deductible of $_____ applied to my policy under the New Hampshire Workers' Compensation Law. This applies to a (1) per claim or (2) per accident or disease (____). I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with New Hampshire revised statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Agent's Name: _____

Policy Number: _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR NEW MEXICO WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

New Mexico Policyholders

New Mexico law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $500 and a maximum of $10,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how thisprogram operates or the savings available, please contact your agent.

DEDUCTIBLE TABLE

DEDUCTIBLE PER ACCIDENT:
$ 500
$ 1,000
$ 1,500
$ 2,000
$ 2,500
$ 5,000
$ 10,000

DATE OF ISSUE: **01-08-25**

Yes, I want a deductible of $_____ applied to my indemnity and medical benefits under the New Mexico Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with New Mexico Laws, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

OKLAHOMA WORKERS COMPENSATION MANDATORY OPTIONAL DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires insurers issuing a policy under the Administrative Workers' Compensation Act ("AWCA") to offer deductibles, optional to the policyholder, for benefits payable under the AWCA.

This form is applicable to the optional deductibles required by 85A O.S. Section 95 and OAC 365:15-1-3.1 only. For larger negotiated deductibles, see OAC 365:15-1-3. 1 and 365:15-1-3.2.

All five deductible options set forth below shall be fully disclosed to the prospective policyholder in writing. The policyholder is not required to select a deductible option, but if the policyholder chooses a deductible, the policyholder may choose only one combined deductible amount. The maximum combined deductible, including medical benefits and indemnity claims, shall be $5,000 per claim. Please carefully review the requirements for the deductible options outlined below.

DEDUCTIBLE OPTIONS

Combined optional deductible amounts are $1,000.00; $2,000.00; $3,000.00; $4,000.00; and $5,000.00.

EMPLOYER OBLIGATIONS IF A DEDUCTIBLE OPTION IS SELECTED

If the applicant employer chooses a deductible, the insurer shall pay compensable claims to the person or medical providers entitled to the benefits conferred by the AWCA, and obtain reimbursement from the insured employer for the applicable deductible amount.

WARNING: The insured employer must reimburse the insurer within sixty (60) days of a written demand. If the insured employer fails to reimburse the insurer within sixty (60) days, the insurer may seek to recover the full amount of such claim from the insured employer. In addition, the non-payment of deductible amounts shall be treated in the same manner as non-payment of premiums.

EXPERIENCE MODIFICATION

Benefits paid by the insured employer under a deductible as provided herein may not be treated as benefits paid so as to harm the experience rating of the employer.

ACCEPTANCE/REJECTION

☐ Yes, I have read the optional deductible information summarized above and want the following deductible amount to apply to claims under the AWCA. I understand that this deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

MEDICAL AND INDEMNITY

☐ $1,000.00

☐ $2,000.00

☐ $3,000.00

☐ $4,000.00

☐ $5,000.00

☐ Yes, I understand that I am responsible for reimbursing my insurance company for the amounts of any deductible it pays.

☐ No, I do not want the optional deductible described in this form.

NAMED INSURED_____

ADDRESS_____

TITLE_____

SIGNATURE_____

DATE_____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

This form is provided pursuant to Oklahoma Administrative code 365:15-1-3.1.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: **UB-1T152983-25-14-G**

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR SOUTH CAROLINA WORKERS' COMPENSATION MEDICAL AND INDEMNITY BENEFITS

South Carolina Policyholders:

South Carolina law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $2,500 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain a copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement (WC 00 06 03) will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available please contact your agent.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL
DEDUCTIBLE PER ACCIDENT: $100, $200, $300, $400, $500, $1,000, $1,500, $2,000, or $2,500

DATE OF ISSUE: **01-08-25**

Yes, I want a deductible of $_____applied to my medical and indemnity benefits under the South Carolina Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with the South Carolina statutes, I have the option of modifying the above deductible program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer's Name: _____

Policy Number: _____

IMPORTANT NOTICE – WORKPLACE NOTICE FOR FIRST RESPONDERS – TEXAS

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

In accordance with 28 TAC §276.5, concerning Employer's Notification of Ombudsman Program and First Responder Liaison to Employees, employers who employ first responders or supervise volunteer first responders must post a copy of the 'Office of Injured Employee Counsel Notice Regarding First Responder Liaison To Assist In Workers' Compensation Disputes'.

This notice informs first responders of a designated Office of Injured Employee Counsel (OIEC) first responder liaison. The definition of "first responder" can be found in Texas Labor Code §504.055.

The text of the 'Office of Injured Employee Counsel Notice Regarding First Responder Liaison To Assist In Workers' Compensation Disputes' notice must be as provided by the OIEC without any additional words or changes. It must be posted in the personnel office and in the workplace where employees or volunteers are likely to read the notice on a regular basis. The notice shall be printed with a title in at least 15 point bold type and text in at least 14 point normal type, in English and Spanish or in English and any other language common to the employer's affected employee population.

A copy of the 'Office of Injured Employee Counsel Notice Regarding First Responder Liaison To Assist In Workers' Compensation Disputes' notice may be obtained by:

1) Downloading the form on the OIEC's website at:
   https://www.sos.texas.gov/texreg/archive/December292017/tables-and-graphics/201705062-2.pdf

   Or:

2) Requesting the notice by calling the first responder liaison office directly at (512) 804-4173.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR HAWAII WORKERS' COMPENSATION MEDICAL BENEFITS

Hawaii Policyholders

Hawaii law now permits an employer to buy Workers' Compensation Insurance with a deductible. This deductible is for medical benefits and applies separately to each bodily injury or accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $10,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement (WC 52 06 01 (A)) will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible on the policy, you may disregard this form. Your policy will continue in force as issued. For a complete explanation of how this program operates or the savings available, please contact your producer.

DEDUCTIBLE TABLE

MEDICAL DEDUCTIBLE SELECTED BY HAWAII EMPLOYER:			
	$100	$750	$4,000
	$150	$1,000	$4,500
	$200	$1,500	$5,000
	$250	$2,000	$7,500
	$300	$2,500	$10,000
	$400	$3,000	
	$500	$3,500	

DATE OF ISSUE: 01-08-25

Yes, I want a deductible of $_____ applied as indicated above under the Hawaii Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that I have the option of modifying the above deductible program choice at the time of renewal of my Workers ' Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer Name: _____

Policy Number: _____ Producer/Company

TRAVELERS

INSIGHT

AN INFORMATION SERVICE FOR CUSTOMERS OF THE TRAVELERS

MARYLAND STATE LAW

MINOR EMPLOYEES MUST HAVE WORK PERMITS

Maryland State Law imposes penalties on employers for hiring minors who do not possess work permits.

COMPENSATION OR DEATH BENEFITS MAY BE DOUBLED

You may have to pay twice as much Workers' Compensation benefits for a minor employed without a work permit.

YOU, THE EMPLOYER, ARE SOLELY LIABLE!

Any increased payments for minor employees without work permits must be paid by you.

Check your current employment roster and review your employment procedures to be certain any minors you employ have work permits.

NEW JERSEY

NOTICE OF ELECTION – PROPRIETORS AND PARTNERS
WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

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

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

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

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

NAME OF BUSINESS _____

COVERAGE IS ELECTED ☐ **COVERAGE IS REJECTED** ☐ **BUSINESS IS A CORPORATION or OTHER FORM OF ORGANIZATION** ☐

Always complete this section

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

Complete this section only when coverage is elected

Signature: _____ Date: _____
Proprietor or a Partner

Always complete this section

Form PP-1B

TRAVELERS

Travelers Medical Provider Network (MPN) Plan – CALIFORNIA
Necessary Action for MPN Participation

Dear Policyholder:

As your workers compensation insurer, Travelers is pleased to include your Company in our California Medical Provider Network (MPN) plan. Travelers has an extensive MPN with physicians who understand workers compensation and are experienced in providing expert care for injured workers. Our program ensures that every covered employee that suffers a work-related injury or illness has access to prompt medical care and an improved likelihood of a safe return to work as soon as medically appropriate. MPN utilization can reduce overall workers compensation claim payouts by providing greater control over medical fees and obtaining more favorable medical treatment outcomes. Your role is crucial to the success of the MPN program. Together, we can better manage your Workers Compensation claims within the MPN.

The MPN is a standard product in all Travelers workers compensation policies, and all policyholders are expected to participate. This information is being provided to you to help you understand the requirements for proper MPN participation.

The State Division of Workers' Compensation (DWC) regulates how an employee is notified of an employer's MPN participation. Section § 9767.12 of Title 8, California Code of Regulations specifies what notices are to be provided to employees, as well as when and how they are to be provided. Information about the Travelers MPN and notice requirements is available to policyholders on **www.travelers.com**. Please type this web address into your browser to access the information:

www.travelers.com/CAMPN

A "**F**requently **A**sked **Q**uestions" page is also available through the above web address. Look for the link called **FAQ – MPN.** If you have additional, general questions regarding the MPN and do not have a contact in the Claim Department, you can contact the **Travelers MPN Team** by calling **(800) 287-9682** or sending an email to **CAMPN@travelers.com**. Please listen for the prompts for *Employers or Employer Representatives*.

In addition to reviewing the information on our web page, we also recommend that you:

- Make sure your management staff has instructions on how to access the MPN Medical Provider directory via **www.travelers.com/CAMPN.**
- Select an occupational medicine clinic, urgent care clinic, or, an acute care hospital from the MPN to serve as your designated initial injury treatment facility for each plant/location. Contact this facility and inform them that you are participating in the Travelers Medical Provider Network Plan. Update the State Posting Notices to include the name, address, and phone number of the facility.
- Review your procedures for handling work-related injuries, your modified duty policy, and your safety committee operation with your management staff.

We believe the MPN program will provide better overall workers compensation outcomes for you as an employer.

Sincerely,

Travelers

MEDICAL AUTHORIZATION

RE: Name: Date:
SS#: Claim Number:
DOB:

YOU ARE HEREBY AUTHORIZED TO RELEASE TO

Travelers Indemnity Company and its Property/Casualty affiliates
or Constitution State Services, LLC
P O Box 3205
Naperville, IL 60566
Fax: 877/786-5567

or any representative acting on its behalf, including my employer, and to permit them to examine and/or copy:

> Any and all hospital records, medical records, psychological records, x-ray films and their reports, all tests of any type and character and their reports, statements of charges and any and all records of medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense in your possession or control pertaining to the undersigned. (Illinois Mental Health and Developmental Disabilities Confidentiality Act – REF. 740 ILCS 110/1 et seq; and, Illinois Workers Compensation Act 820 ILCS 305/8(a))

You are also authorized to discuss with them my injuries, physical condition, treatment and care and to furnish them with a written report regarding same.

The purpose for releasing this information is:

(A) To facilitate the evaluation of my claim for Workers' Compensation benefits. (REF: 50 IL Admin Code, Ch II § 7110.70).

(B) To permit said disclosed information to be admitted into evidence at a hearing on my claim for said benefits pursuant to the appropriate rules of practice before the Illinois Workers' Compensation Commission.

A photostatic copy of this authorization shall be as valid as the original. This authorization is valid for the duration of the claim.

You are hereby released from any and all liability or responsibility, which could or might result because of the disclosure of any information pursuant to this authorization.

_____ _____

DATE SIGNATURE

_____

PRINT NAME

North Carolina Industrial Commission

IC File #_____

REPORT TO WORK REPORT

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employer FEIN_____

Employee's Name	Employer's Name ( ) Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier
( ) ( ) Home Telephone Work Telephone	Carrier's Address City State Zip
☐ M ☐ F / / Social Security Number Sex Date of Birth	( ) ( ) Carrier's Telephone Number Fax Number

Employer: The use of this form is not appropriate when an employee has returned to work on a trial return to work basis pursuant to N.C. Gen. Stat § 97-32.1, in which case Form 28T must be used. By using this form you are stating that this case is not a trial return to work and that one of the exclusions contained in NCIC Rule 404A(7) applies .

Important Notice To Employee: Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. If your trial return to work is unsuccessful, you should complete form 28U in order to request that your compensation be reinstated.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING

1. Date of injury: _____
2. Date disability began: _____
3. Date returned to work: _____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES:

Employee is being paid at the rate of $ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer: _____
2. Address: _____
3. Telephone: _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR TITLE DATE

Employer: The original of this form shall be sent to the address below, and a copy sent to the employee and the employee's attorney of record, if any. A Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

FORM 28
2/01
PAGE 1 OF 1

MAIL TO: *NCIC - CLAIMS SECTION*
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

W32S2C01

State of Hawaii
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION

GUIDE FOR COMPLETING AND FILING INDUSTRIAL ACCIDENT REPORTS UNDER HAWAII'S WORKERS' COMPENSATION LAW

FOR EMPLOYERS AND INSURANCE CARRIERS

This guide was prepared by the Disability Compensation Division of the Department of Labor and Industrial Relations to assist employer and insurance carrier personnel responsible for industrial injury administration. It is designed primarily to assist personnel presently engaged in accident claims processing and to serve as the training aid when new personnel are hired to do this work.

REPORTS

A. EMPLOYEE'S REPORT OF INDUSTRIAL INJURY (WC-1)

The law provides that every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported and submitted within 7 working days to the Disability Compensation Division, hereinafter referred to as (DCD). The 7 working days limitation runs from the first day the employer has knowledge of the occurrence of the accident and for this purpose where supervisory personnel of the employer learn of the accident, the employer is deemed to have knowledge of the accident

The Employer's Report of Industrial Injury is the basic accident document and for this reason every applicable question and item must be answered accurately to avoid further effort on the part of the DCD and you. It should be borne in mind that further effort entails unnecessary additional work and creates greater processing costs for all concerned.

COMPLETING THE WC-1

Please do not write in the shaded blocks. These spaces are for Division use only for computer code entry.

1. IDENTIFICATION SECTION

Name of employee. Enter the employee's name correctly - last name first. In this respect, it would be advisable to enter the name as shown on the employee's social security identification card.

Employee's social security number. The employee's correct social security number is necessary and must be included.

Employee's date of birth. An employee's correct date of birth is an important identification factor, as well as being a benefits level determinant for injured workers who are under age 25.

Employee's sex and marital status. Place an (X) in the appropriate box.

Employee's address. Self-explanatory. The employee's home address should be used whenever possible rather than a post office box number. Any change of address following submission of WC-1 to the Disability Compensation Division should be communicated to the Division as soon as practicable. Any additional information should be entered in the appropriate box. City, State and zip code should be properly entered.

Employee's occupation. Enter the employee's occupation, i.e. carpenter, structural ironworker, heavy duty mechanic, auto mechanic, truck driver, laborer, sales clerk, bookkeeper, cashier, cable splicer, pressman, etc.

How long employed by you at this occupation? Self-explanatory.

Employee's department. Enter the name of the department to which employee was assigned at the time of injury or illness, whether or not employee was actually working in the department at the time. In the absence of formal department titles, enter a brief description of normal work place to which employee is assigned.

Employee's compensation class code. Enter the employee's rating manual occupation class code. This information is for the Hawaii Insurance Rating Bureau to assure proper payroll class designation for proper rating and premium determination.

Name of employer. Enter name of employer exactly as the employer's name appears on the workers' compensation insurance policy or as a self-insurer on the certificate of self-insurance.

Employer's address. Self-explanatory.

Nature of business. Enter the principal type of business activity engaged in, i.e. restaurant, service station, contracting, auto repair shop, etc.

Date injury or illness reported. Enter the date the employer was informed of the injury or illness. For this purpose, a foreman, supervisor, or any other management personnel is considered the employer.

Date of injury or illness. Self-explanatory.

DOL number. Enter the Department of Labor (DOL) account number which is the same as your Unemployment Insurance (UI) or Temporary Disability Insurance (TDI) account number.

2. DETAILS OF INJURY/ILLNESS

Time of injury/illness. Self explanatory.

Place of injury/illness if different from mailing address. Enter address or brief description of location where injury/illness occurred if different from premises or principal place of business previously designated as employer (mailing) address.

How did this accident occur. What was employee doing when injured. Object or substance that directly injured the employee. Self-explanatory. Should be sufficiently detailed to provide complete explanation or description.

Describe in detail the nature of the injury/illness and part of the body affected. Describe the injury fully clearly designating the affected part of the body, i.e. amputation of right arm, crushing injury to chest, lead poisoning, dermatitis of right arm and hand, etc.

3. TIME LOST INFORMATION

Date disability began. If the employee could not complete his workday because of the accident, enter here the date of the accident If the employee worked his scheduled hours on the day of the accident, then enter the date of the first day his disability started.

Was employee furnished meals or lodging? In the event the worker is furnished meals or lodging, enter yes and the market value of each.

Average weekly wage. Wage information on an employee is a very important and significant factor in a claim. A claimant's wage establishes the basis and the rate at which weekly compensation payments must be made if the employee is temporarily disabled for work or sustains a permanent disability from the accident, or in the case of death, dependency benefits.

Section 386-51 of the Workers' Compensation Law mandates the computation of average weekly wage in a manner that the result represents most fairly, in the light of a worker's employment pattern and duration of disability, his average weekly wage from all employment covered by the law at the time of the injury. Generally, it is a relatively simple calculation.

(a) Where an employee works a regular 40-hour workweek and

- **(1)** is employed only at a rate per hour, multiply the hourly rate by 40 and the result is the average weekly earnings.
- **(2)** is only on a pre-determined and fixed semi-monthly salary, multiply the semi-monthly salary by 24 (months) then divide by 52 (weeks) and the result is the average weekly earnings.
- **(3)** is only on a pre-determined and fixed monthly salary, multiply the monthly salary by 12 (months) then divide by 52 (weeks) and the result is the average weekly earnings. (A monthly salary multiplied by factor .2308 also yields the average weekly earnings.)

(b) Where an employee is injured in part-time employment the average weekly wage cannot be lower than that of an employee in comparable employment. In such a case, obtain the average weekly wage of an employee working on a full-time basis in the same occupation. It should be noted, however, that in the event there is no comparable employment, the average weekly wage cannot be less than the injured employee's hourly rate multiplied by 35 (hours).

(c) Where an employee is employed in more than one employment (i.e. full-time with one employer and part-time for another or part-time with both employers) his earnings from both jobs must be included in arriving at his average weekly wage. The employer in whose employment the injury occurred has to obtain the injured employee's earnings from the other employment. In such a case, indicate this under Item 12 or on the reverse of the form. If the employee is injured in the part-time employment, also refer to **(b)** above.

(d) Where an employee has had overtime earnings and/or bonuses which caused fluctuations in his earnings, take his total earnings for the twelve months preceding his injury and divide it by 52 weeks to get his average weekly earnings. If, however, because of sickness or other personal circumstances he did not work all of the 52 weeks, then use the number of weeks worked as a divisor instead of 52.

(e) Where an employee at the time of the injury was employed at a higher rate of pay than anytime during the twelve months preceding the injury, determine his average weekly earnings solely on the higher rate of pay.

Where an employee at the time of the injury was employed at higher wages than any other period of the preceding twelve months and had earned overtime pay during the twelve-month period, the average weekly overtime hours obtained by dividing the total overtime hours worked during the twelve-month period by 52 shall be multiplied by the overtime hourly rate based on the higher wages, and the product shall be added to the weekly straight time pay obtained by multiplying the straight time hourly rate based on the higher wages by the total number of straight time hours normally worked by the employee in a work week.

(f) Where an employee is under 25 years of age and sustains an injury causing permanent disability or death his average weekly wage shall be computed on the basis of the wages he would have earned in his employment had he been 25 years of age. In applying this provision of the law, the average weekly wage is determined as follows:

(1) Where the employee is employed in an occupation or job classification as an apprentice or trainee under the terms of an apprenticeship or on-the-job training program his average weekly wage shall be calculated on the basis of the rate of pay he would receive at age 25 under the apprenticeship or trainee agreement, plan, or contract. An apprenticeship or on-the-job training program is one which is registered with the Department of Labor and Industrial Relations, expressed in writing in a collective bargaining agreement or an employment contract, or one which the Director determines bears substantial similarities to that of an on-the-job or career training program based on a mutual employer-employee understanding.

(2) Where the employee is employed in an occupation or job classification and is not an apprentice or trainee, his average weekly wage shall be determined on the basis of the median rate of pay of the lowest and highest rate of pay of twenty-five year old employees employed in a similar occupation by his employer.

If there are no twenty-five year old employees in a similar occupation with the same employer, obtain the median rate of pay of twenty-five year olds in a similar occupation in employment with another employer in this State.

Whenever confronted with circumstances which this guideline does not provide adequate guidance, it is suggested that the Disability Compensation Division be contacted for assistance in determining the average weekly wage.

If employee is back to work, give date. Enter date employee returned to work.

If employee died, give date. If the injury resulted in death, give date employee died.

Give name and address of survivors on back. Names and addresses of surviving spouse, minor dependent children, and/or other survivors should be listed on back.

Hourly wage. If the employee is employed on an hourly basis, state the rate per hour.

Monthly salary. If the worker is on a fixed monthly salary, enter the amount of the salary.

Hours worked per week. Self-explanatory. Should include overtime hours.

4. TREATMENT

Name of physician - hospital. Self-explanatory.

5. INSURANCE

Name of workers' compensation insurance company. Enter the name of the insurance company as it appears on the insurance policy and if employer is a self-insurer, enter "self-insurer".

Name of general agency. If a general agent handles or administers the workers' compensation affairs for your insurance carrier, enter the full name of the agent. If an adjuster is administering or handling the workers' compensation affairs for the insurance carrier or the general agent, then also show the full name of the adjuster under this item.

If liability denied - why? Is liability denied? The usual order is reversed for date entry purposes. These questions are very important and must be entered. If liability is denied, mark "yes" and briefly state reason for denial.

MORE ON THE WC- 1

- The person submitting this report must be mindful that it has to be in the office of the DCD within 7 working days from the date the employer has knowledge of the accident.
- This report has to be retained by the DCD for a long time and in many cases up to 60 years, so it should be typed or completed in ink. The ORIGINAL and first copy shall be sent to the DCD if the accident occurred on Oahu. If the accident occurred on a neighbor island, the original and first two copies shall be sent to the appropriate district office of the Department of Labor and Industrial Relations.
- A copy of this report must be furnished to the injured employee.

B. CARRIER'S CASE REPORT (WC-3)

This form replaces previous forms WC-3a, Employer's Supplemental Report of Industrial Injury and WC-4, Employer's Final Report of Industrial Injury. The reporting requirements remain unchanged except that the WC-3, Carrier's Case Report, is to be used to report both supplemental and final payment information.

The completion and filing of the WC-3 as a supplemental report or as a final report is required by Section 386-95 of the Workers' Compensation Law. The supplemental report must be executed and submitted to the DCD no later than January 31 of each year on every accident case that is in "open status" on December 31 of each year. An "open status" case is one which up to December 31 of each year has not been closed by the submission of a Final Report, and the carrier or self-insurer has made payments on the case. Payments include any expenses on the case which the law requires.

A final report must be submitted after all payments on an industrial accident case have been completed. This means that all medical, hospital and other expenses have been paid and no further weekly or other compensation payments are due the claimant or dependents. The Workers' Compensation Law requires the submission of this report to the DCD within 30 days after final payment of compensation.

In addition a WC-3 must be submitted when: (1) payments are starting; (2) a case is reopened; (3) a hearing is requested; (4) a medical only case (often referred to as an open/close) is submitted, and (5) an adjustment or additional payment is made on an ended case.

Case number. Enter the DCD case number. This information should have been furnished you by the DCD following submission and processing of the WC-1.

Carrier case number. Enter here the insurance carrier or self-insurer case or file number.

Carrier I.D. This code or number to be entered by DCD. May be entered by insurance carrier or self-insurer if number known.

Claimants name and address. Enter the employee's name and address as it appears on the WC-1. If employee's address was changed subsequent to the submission of the WC-1, his current address should be shown and appropriately indicated as a change of address or current address.

Social security number. Enter employee's correct social security number as shown on the WC-1.

Date of injury/illness. Enter the date of injury or illness as shown on the WC-1.

Employer. Be sure to enter the employer's name as furnished initially on the WC-1.

Carrier name, address. Enter name of insurance carrier or self-insurer exactly as shown on WC-1. If claim is being handled by an insurance agency or an independent adjuster, it's name and address should appear under name of carrier.

Individual to contact. Please enter here the name of the insurance carrier, agent, adjuster, self-insured employer representative to whom inquiries regarding the WC-3, payment, and/or other claims information may be directed.

Telephone number. Enter the phone number of the representative to be contacted.

CHECK ONE. These spaces indicate the type of report being made. One and only one box should be checked.

1. **Date of first income replacement payment**. Check box and enter date first TTD payment made. Payment information should also be furnished.
2. **Reopen case.** Check box if case is being reopened because of recurring symptoms or additional medicals, etc.
3. **Hearing requested.** This box should be checked if a hearing is being requested.
4. **Medical only**. If the case involves medical payments only, and is, in effect, being opened and closed, then check this box and enter the date the payment was made, Also furnish numeric payment information in payment block. (Reminder: No report need be made unless the injury causes absence from work for one day or more or requires medical treatment beyond ordinary first aid.)
5. **Final payment to previously ended case.** This box should be checked when a final payment or adjustment is being made to amend or correct a payment error made in a previous ended case.
6. **Year end report.** Check this box to indicate that report is a supplemental or year end report. Be sure to indicate the payment year report is for, and include payment information in appropriate payment boxes.
7. **Final report** This box is to be checked if report is a final report. Enter all payment and expense information.

Return to work date. Enter date and submit report as soon as the date employee returned to work is known.

Payment block. Self explanatory. Amount blocks, disfigurement, medical other, and services of attendant must be numeric dollars and cents figures.

Carrier comments. Use this space to communicate with the DCD if you have a reason to do so, e.g. You may want to say that the claimant was discharged from further medical care, etc.

MORE ON THE WC-3.

- This report must be typed or completed in ink. If the accident occurred on Oahu, send the original of this report to DCD. If accident occurred on a neighbor island, then submit the original and first copy to the appropriate District Office of the Department of Labor and Industrial Relations.
- If report is a year end or final report, a copy of this report must be furnished to the injured employee.

DISCLOSURE FORM
WORKERS' COMPENSATION INSURANCE

IMPORTANT NOTICE TO POLICYHOLDERS

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

1. NOTICE OF CHANGE IN RATE BY CLASSIFICATION

If you desire information whenever there is a change in your workers' compensation insurance rate by classification, you must request such information from your insurer. This request for information must be in writing.

2. NOTICE OF POLICYHOLDERS' RIGHT TO APPEAL CLASSIFICATION

Your insurer can charge and collect any additional amount of money not included in the initial premium charged as a result of job misclassification.

If you have any questions regarding the employee classification assigned to calculate your workers' compensation insurance premium, you need to direct your questions to your insurer or the insurer's authorized representative within either thirty (30) days after the effective date of the policy or the date of receipt by you of notice of a change in job classification. Within thirty (30) days after receipt of your request for information, your insurer or the insurer's authorized representative must explain to you why a particular employee classification was used.

If you disagree with your insurer or the insurer's authorized representative on the employee classification assignment, you may appeal to the Workers' Compensation Classification Appeal Board by filing written notice with said board within thirty (30) days after you have exhausted all appeal review procedures provided by the insurer. Your request should be sent to the Secretary of the Colorado Workers' Compensation Classification Appeals Board, Michael Craddock, c/o National Council on Compensation Insurance, Inc. (NCCI), 901 Peninsula Corporate Circle, Boca Raton, FL 33487. Written instructions for your appearance before the Colorado Workers' Compensation Classification Appeals Board will be furnished by the Secretary of the board. The board will render a decision as to whether a misclassification has occurred.

A decision by the board is final and not subject to appeal unless you, the insurer provides written notice of appeal within thirty (30) days after the board's decision to the office of the Commissioner of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. The Commissioner shall review any decision of the board properly appealed.

3. NOTICE OF AVAILABILITY OF MEDICAL CASE MANAGEMENT SERVICES

We have many types of medical case management services available and suggest that you contact our local claim office for an explanation of services available to you.

New York Notice to Employers

The Construction Employment Payroll Limitation Law, enacted under Senate Bill S7744 and Assembly Bill A11294, provides a more equitable distribution of premium between high wage paying and low wage paying employers in the construction industry. One or more classification codes applicable to your policy may be subject to the Payroll Limitation Law. ***See list of eligible classifications below.*** The Law does not, however, apply to employments engaged in the construction of one or two family residential housing.

Your overall premium may increase or decrease depending on geographic territories and/or payroll limitations. The actual weekly payroll of each employee performing the employments subject to an eligible classification code is subject to the following limitations:

- a maximum of $1,450.17 for the weekly wage upon which the maximum weekly benefit is based for policies with effective dates on or after July 1, 2020.
- a maximum of $1,594.57 for the weekly wage upon which the maximum weekly benefit is based for policies with effective dates on or after July 1, 2021.
- a maximum of $1,688.19 for the weekly wage upon which the maximum weekly benefit is based for policies with effective dates on or after July 1, 2022.
- a maximum of $1,718.15 for the weekly wage upon which the maximum weekly benefit is based for policies with effective dates on or after July 1, 2023.

The construction employment geographic territories are:

Territory 1 – Counties of the Bronx, Kings, New York, Queens and Richmond

Territory 2 – Counties of Duchess, Nassau, Orange, Putnam, Rockland, Suffolk and Westchester

Territory 3 – All other counties within the State

Please note that since your operations may be subject to the law, an employer with an eligible classification code is required to maintain true and accurate weekly records for each employee that shows:

1. Each employee's total weekly wages and hours worked;
2. The type of work performed;
3. The geographic territory in which the work was performed; and
4. Whether or not the work was performed on commercial structures or on one/two family residential housing.

Eligible classification codes are those currently contained in the New York Construction Classification Premium Adjustment Program (PAP), with the exception of code 5645, which applies to the construction of one or two family residential dwellings. The specific listing of eligible classification codes is as follows:

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

The definition of the term "construction" as used in the Payroll Limitation Law includes new construction, as well as the remodeling, repair and maintenance work on existing structures.

If you have any questions regarding this law, please contact your agent, broker or insurance carrier underwriter.

NOTICE – IMPORTANT INFORMATION REGARDING YOUR INSURANCE – VIRGINIA

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

Should you need to contact anyone about this insurance for any reason, please contact your agent. If you have additional questions you may contact Travelers at:

One Tower Square
Hartford, CT 06183
1-800-328-2189

Travelers.com

If you have been unable to contact or obtain satisfaction from our company or your agent, you may contact the Virginia State Corporate Commission's Bureau of Insurance at:

State Corporation Commission, Virginia Bureau of Insurance
PO Box 1157
Richmond, VA 23218

Toll free: 1-877-310-6560
Richmond, VA area: 804-371-9741

Email: bureauofinsurance@scc.virginia.gov

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

IMPORTANT NOTICE – COPYRIGHT

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

The National Council on Compensation Insurance and certain state workers compensation bureaus require a copyright notice on policy forms that contain their copyrighted material. This Important Notice addresses this copyright notice requirement for any policy form included in this policy that does not separately contain a copyright notice.

For all policy forms other than the workers compensation bureau forms of the states identified below:

Includes copyright material of the National Council on Compensation Insurance, Inc. used with its permission.

© 1983-2025 National Council on Compensation Insurance, Inc. All Rights Reserved

For the workers compensation bureau policy forms of the following states:

DELAWARE:

© 2025 Delaware Compensation Rating Bureau

MICHIGAN:

Includes copyright material of the National Council on Compensation Insurance, Inc. and the Michigan Workers' Compensation Placement Facility, used with their permission.

MINNESOTA:
© 1992- 2025 Minnesota Workers' Compensation Insurers Association, Inc. All Rights Reserved.

NEW JERSEY:
© Compensation Rating and Inspection Bureau

NEW YORK:
© 1987- 2025 New York Compensation Insurance Rating Board

NORTH CAROLINA:
© 2008- 2025 North Carolina Rate Bureau. Includes copyright material of the National Council on Compensation Insurance, Inc. used with its permission.

PENNSYLVANIA:

© 2025 Pennsylvania Compensation Rating Bureau

IMPORTANT NOTICE – NEW, UNCOLLECTED OR UNCONTEMPLATED SURCHARGES

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

The insurer is responsible for the collection of any surcharge related to the policy premium in accordance with state laws or regulations. While surcharges are commonly known at the time of policy issuance, there are instances when a state amends existing, or institutes new, surcharge rates after policy issuance. The insured is responsible to reimburse the insurer when billed for the amount of any surcharge.

STATE OF CALIFORNIA
IMPORTANT LOSS CONTROL INFORMATION

California Labor Code § 6354.5 (b)(3) requires workers' compensation insurance carriers to provide their California policyholders with occupational safety and health loss control consultation services at no additional charge. See the enclosed Safety Services notice for a list of services available and for the phone number and address of the Travelers Risk Control office nearest you.

Notice To Policy Recipient:

If you are not the person directly responsible for the loss control activities of your company in California, please direct these safety services notices to the person directly responsible for loss control activities.

IMPORTANT NOTICE TO CALIFORNIA EMPLOYERS

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

California Labor Code Section 3550 requires you to post and keep posted in each of your California workplaces, in a conspicuous location frequented by employees, a notice that states the name of your current workers compensation insurance carrier and who is responsible for claims adjustment. The notice must be posted in English and Spanish if you have Spanish-speaking employees. Failure to keep the notice posted as required constitutes a misdemeanor.

For your convenience, we have enclosed copies of notice DWC 7, Notice to Employees – Injuries Caused by Work, for each of your California locations.

POLICYHOLDER NOTICE

SHORT RATE CANCELATION
CALIFORNIA INSURANCE CODE SECTION 481

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

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

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

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

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

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

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

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

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

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

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

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

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

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us – Travelers Property Casualty Company of America

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

TRAVELERS
P.O. Box 6512
21688 Gateway Center Drive
Diamond Bar, CA 91765
Telephone: 1-909-612-3609
Fax: 1-909-612-3629
Website: www.travelers.com

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

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

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

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

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan–1995* (USRP) and the *California Workers' Compensation Experience Rating Plan–1995* (ERP). WCIRB contact information is: WCIRB, 1901 Harrison Street, 17th Floor, 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, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

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

II. Dispute Process

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

A. Our Dispute Resolution Process.

If you are aggrieved by our decision adopting a change in a classification assignment that results in increased premium, or by the application of our rating system to your workers' compensation insurance, you may dispute these matters with us. If you are dissatisfied with the outcome of the initial dispute with us, you may send us a written Complaint and Request for Action as outlined below.

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

TRAVELERS
1109 White Rock Road
Rancho Cordova, CA 95670-6001

Phone: 1-800-328-2189

Website: www.Travelers.com

TRAVELERS
P.O. Box 6512
21688 Gateway Center Drive
Diamond Bar, CA 91765
Phone: 1-909-612-3609
Fax: 1-909-612-3629
Website: www.Travelers.com

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether 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, 1901 Harrison Street, 17th Floor, 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 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, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).**

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

Administrative Hearing Bureau
California Department of Insurance
1901 Harrison Street, 3rd Floor Mailroom
Oakland, CA 94612
415.538.4243

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

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

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1901 Harrison Street, 17th Floor, 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 INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent, the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" or "CA Surcharge (CIGA) Surcharge)" with an amount will be displayed on your premium notice.

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

Time of Hire Notice

This notice, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this notice applies to all industrial injuries that occur on or after January 1, 2013.

WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin or getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your hand, back, or other part of your body from doing the same repeated motion or losing your hearing because of constant loud noise

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

Discrimination is Illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

WHAT ARE THE BENEFITS

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

- **Temporary Disability (TD) benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two- thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary Disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.

- **Permanent Disability (PD) benefits:** Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:
    - Your doctor's medical reports
    - Your age
    - Your occupation

- **Supplemental Job Displacement Benefits (SJDB):** This is a voucher for up to $6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job.
  You are eligible for this voucher if:
    - You have a permanent disability.
    - Your employer does not offer regular, modified, or alternative work, **within 60 days** after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.

- **Return-to-Work Supplemental Program (RTWSP):** For dates of injury after 1/1/2013, you may qualify for additional money from the Division of Workers' compensation program known as the Return-to-Work Supplement Program (RTWSP) if you received the Supplemental Job Displacement Voucher (SJDB). If you have questions or think you qualify, contact the Information & Assistance Unit by calling 1-800-736-7401 or visit website: **https://www.dir.ca.gov/RTWSP/RTWSP.html**

- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least $224 per week. In addition, workers' compensation provides a burial allowance.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site **www.edd.ca.gov**.

Workers' compensation fraud is a crime
Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers' compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to $150,000 and/or serve up to five years in jail.

WHAT SHOULD I DO IF I HAVE AN INJURY?

Report your injury to your employer
Tell your supervisor right away no matter how slight the injury may be. Don't delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job. If you cannot report to the employer or don't hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

Workers' compensation insurance company or if employer is self-insured, person responsible for handling the claim is:

_____

Address: _____

Phone: _____

You may be able to find the name of your employer's workers' compensation insurer at **www.caworkcompcoverage.com**. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at **www.dir.ca.gov/DLSE** as all employees must be covered by law.

Get emergency treatment if needed
If it's a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for treatment.

Emergency telephone number: Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

_____

Fill out DWC 1 claim form and give it to your employer

Your employer must give you a **DWC 1 claim form** within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within **one working day** of receiving the **DWC 1 claim form**. If the injury is from repeated exposures, you have **one year** from when you realized your injury was job related to file a claim.

In either case, you may receive up to **$10,000** in employer-paid medical care until your claim is either accepted or denied. The claims administrator has **up to 90 days** to decide whether to accept or deny your claim. Otherwise, your case is presumed payable. Your employer or the claims administrator will send you "benefit notices" that will advise you of the status of your claim.

MORE ABOUT MEDICAL CARE

What is a Primary Treating Physician (PTP)?

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing before you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have a MPN.

What is a Medical Provider Network (MPN)?

A MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using a MPN. If you have not named a doctor before you get hurt and your employer is using a MPN, you will see a MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation?

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing before you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the "predesignation of personal physician" form included with this notice. After you fill in the form, be sure to give it to your employer. If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing before you get hurt. You may use the form included in this notice. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn't work, get help by trying the following:

Contact the Division of Workers' Compensation (DWC) Information and Assistance (I&A) Unit. All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.
To contact the nearest I&A Unit, go to **https:// www.dir.ca.gov/dwc/ianda.html**
or call **1-800-736-7401**.

The nearest I&A Unit is located at:
Address: _____
Phone number: _____

Consult with an attorney
Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at **1-415-538-2120** or go visit their website at **www.californiaspecialist.org**. You may also get a list of attorneys from your local I&A Unit by calling **1-800-736-7401**.

Warning
Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

You may also have other rights under the Americans with Disabilities Act (ADA) or the California Fair Employment and Housing Act (FEHA). For additional information, contact California Civil Rights Department (CRD) at 1-800-884-1684 or the Equal Employment Opportunity Commission (EEOC) at 1-800-669-4000.

The information contained in this notice conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883.
This document is approved by the Division of Workers' Compensation Administrative Director.

Please visit the Division of Workers' Compensation website at: **www.dwc.ca.gov** or call 1-800-736-7401

Department of Industrial Relations
1515 Clay Street, 17th Floor
Oakland, CA 94612

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by: _____
(name of doctor)(M.D., D.O., or medical group)

_____ (street address, city, state, ZIP)

_____ (telephone number)

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses: _____

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.

DWC FORM 9783 (7/2014)

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(Telephone number)

Employee Name **(please print):** _____

Employee's Address:

_____

Employee's Signature _____ Date: _____

Title 8, California Code of Regulations, section 9783.1. (Optional DWC Form 9783.1 Effective date July 1, 2014)

Aviso para el nuevo empleado

Este aviso, o uno similar que haya sido aprobado por el Director Administrativo, deben entregarse a todos los empleados recién contratados en el estado de California. Los empleadores y administradores de reclamos pueden utilizar el contenido de este documento y colocar en él sus logotipos e información adicional. El contenido de este folleto se aplica a todos los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.

¿QUÉ ES LA COMPENSACIÓN DE TRABAJADORES?

Si se lesiona en el trabajo, su empleador está obligado por ley a pagarle beneficios de compensación de trabajadores. Podría resultar herido por:

Un suceso en el trabajo. Ejemplos: hacerse daño en la espalda en una caída, quemarse con un producto químico que le salpique la piel o lesionarse en un accidente de automóvil mientras hace repartos.

—o—

Exposiciones repetidas en el trabajo. Ejemplos: lastimarse la mano, la espalda u otra parte del cuerpo por hacer el mismo movimiento repetido o perder la audición por ruidos fuertes y constantes.

—o—

Delitos en el lugar de trabajo. Ejemplos: resulta herido en un atraco a una tienda, es agredido físicamente por un cliente descontento.

La discriminación es ilegal

Según la sección 132a del Código Laboral, es ilegal que su empleador lo castigue o despida porque usted:

- Presenta un reclamo de compensación de trabajadores
- Tiene intención de presentar un reclamo de compensación de trabajadores
- Concilia un reclamo de compensación de trabajadores
- Testifica o tiene intención de testificar por otro trabajador lesionado

Si se determina que su empleador lo ha discriminado, puede ordenársele que lo reincorpore a su puesto de trabajo; su empleador también puede verse obligado a pagar los salarios perdidos, el aumento de los beneficios de compensación por accidentes laborales y los costos y gastos establecidos por la legislación estatal.

¿CUÁLES SON LOS BENEFICIOS?

- **Atención médica:** pagada por su empleador para ayudarlo a recuperarse de una lesión o enfermedad causada por el trabajo. Las visitas al médico, los servicios hospitalarios, la fisioterapia, las pruebas de laboratorio y las radiografías son algunos de los servicios médicos que pueden prestarse; estos servicios deben ser necesarios para tratar su lesión. Existen límites para algunos servicios, como la fisioterapia, la terapia ocupacional y la quiropráctica.

- **Beneficios por discapacidad temporal (Temporary Disability, TD):** pagos si pierde salario porque su lesión le impide realizar su trabajo habitual mientras se recupera. El monto que puede recibir es de hasta dos tercios de su salario. Existen límites mínimos y máximos de pago establecidos por la legislación estatal; se le pagará cada dos semanas si es elegible. Para la mayoría de las lesiones, los pagos no pueden superar las 104 semanas en un plazo de cinco años a partir de la fecha de la lesión. La discapacidad temporal (TD) finaliza cuando vuelve al trabajo, o cuando el médico le da el alta para trabajar o dice que su lesión ha mejorado todo lo que va a mejorar.

- **Beneficios por discapacidad permanente (Permanent Disability, PD):** pagos si no se recupera del todo. se le pagará cada dos semanas si es elegible. Existen tasas de pago semanales mínimos y máximos establecidos por la legislación estatal; el monto del pago se basa en:

    - Los informes médicos de su doctor.
    - Su edad.
    - Su profesión.

- **Beneficio suplementario por el desplazamiento de trabajo (Supplemental Job Displacement Benefits, SJDB):** se trata de un vale de hasta $6,000 que puede utilizar para volver a capacitarse o mejorar sus conocimientos en una escuela aprobada, para libros, herramientas, licencias o tarifas de certificación, u otros recursos que lo ayuden a encontrar un nuevo empleo; Es elegible a este vale si:

    - Tiene una discapacidad permanente.
    - Su empleador no le ofrece un trabajo regular, modificado o alternativo, **dentro de los 60 días** posteriores a que el administrador de reclamos reciba un informe médico que indique que usted ha logrado una recuperación médica máxima.

- **Programa Suplementario de Regreso al Trabajo (Return-to-Work Supplemental Program, RTWSP):** para las fechas de lesión después del 1 de enero de 2013, usted puede calificar para dinero adicional del programa de la División de Compensación de Trabajadores conocido como el Programa Suplementario de Regreso al Trabajo (RTWSP) si usted recibió el vale de los Beneficios Suplementarios por el Desplazamiento de Trabajo (SJDB). Si tiene alguna pregunta o cree que reúne los requisitos, póngase en contacto con la Unidad de Información y Asistencia llamando al 1-800-736-7401 o visite el sitio web: https://www.dir.ca.gov/RTWSP/RTWSP.html

- **Beneficios por muerte:** pagos a su cónyuge, hijos u otras personas a su cargo si fallece a causa de una lesión o enfermedad laboral. El monto del pago depende del número de personas a cargo. El beneficio se paga cada dos semanas a una tasa de, como mínimo, **$224 semanales**; además, la compensación de trabajadores prevé un subsidio de sepelio.

OTROS BENEFICIOS

Puede presentar un reclamo ante el Departamento de Desarrollo del Empleo (Employment Development Department, EDD) para obtener beneficios estatales por discapacidad cuando los beneficios de compensación de trabajadores se retrasen, denieguen o hayan finalizado. Hay restricciones de tiempo, así que para más información póngase en contacto con la oficina local del EDD o visite su sitio web: **www.edd.ca.gov**.

El fraude en la compensación de trabajadores es delito
Toda persona que realice o haga realizar cualquier declaración deliberadamente falsa con el fin de obtener o denegar beneficios o pagos de compensación de trabajadores es culpable de un delito grave; si es declarada culpable, la persona tendrá que pagar multas de hasta $150,000 o cumplir hasta cinco años de cárcel.

QUÉ DEBO HACER SI TENGO UNA LESIÓN?

Informe la lesión a su empleador

Informe inmediatamente a su supervisor, por leve que sea la lesión; no se demore, hay plazos. Puede perder el derecho a los beneficios si su empleador no se entera de su lesión en un plazo de 30 días. Si su lesión o enfermedad se desarrolla con el tiempo, notifíquelo en cuanto sepa que ha sido causada por su trabajo. Si no puede informar al empleador o no tiene noticias del administrador de reclamos después de haber informado sobre su lesión, comuníquese usted mismo con el administrador de reclamos.

La persona responsable de tramitar la reclamos de la compañía de seguros de compensación por accidentes laborales, o si il empleado está:

_____

Dirección:

Teléfono:

Puede encontrar el nombre de la compañía de seguros de compensación de trabajadores de su empleador en www.caworkcompcoverage.com. Si no existe cobertura o ésta ha expirado, póngase en contacto con la División de Cumplimiento de las Normas Laborales en www.dir.ca.gov/DLSE ya que todos los empleados deben tener cobertura por ley.

Reciba tratamiento de urgencia si es necesario

Si se trata de una urgencia médica, acuda de inmediato a urgencias. Informe al proveedor médico que lo atiende de que su lesión está relacionada con el trabajo. Su empleador puede indicarle dónde acudir para recibir tratamiento

Número de teléfono de urgencias: llame al 911 para pedir una ambulancia, a los bomberos o a la policía. Para recibir atención médica no urgente, póngase en contacto con su empleador, con el administrador de reclamos de compensación por accidentes laborales o acuda a este centro: _____

Rellene el formulario de reclamos DWC 1 y entréguelo a su empleador

Su empleador debe entregarle un Formulario de reclamos DWC 1 en el plazo de un día hábil tras conocer su lesión o enfermedad. Rellene la parte correspondiente al empleado, fírmela y devuélvala a su empleador. A continuación, su empleador presentará el reclamo al administrador de reclamos. Su empleador debe autorizar el tratamiento en el plazo de un día hábil a partir de la recepción del **formulario de reclamos DWC 1**. Si la lesión se debe a exposiciones repetidas, dispone **de un año** desde el momento en que se dio cuenta de que su lesión estaba relacionada con el trabajo para presentar un reclamo.

En ambos casos, puede recibir hasta $10,000 en concepto de atención médica pagada por el empleador hasta que se acepte o deniegue su reclamo. El administrador de reclamos tiene hasta 90 días para decidir si acepta o rechaza su reclamo; de lo contrario, su caso se presume pagadero. Su empleador o el administrador de reclamos le enviarán "avisos de beneficios" que le informarán de la situación de su reclamo.

MÁS SOBRE LA ATENCIÓN MÉDICA

¿Qué es un médico tratante principal (Primary Treating Physician, PTP)?

Es el médico responsable del tratamiento de su lesión o enfermedad. Él o ella pueden ser:

- El médico que nombra por escrito antes de lesionarse en el trabajo.
- Un médico de la red de proveedores médicos (Medical Provider Network, MPN).
- El médico elegido por su empleador durante los 30 primeros días de la lesión si su empleador no dispone de una MPN.
- El médico que haya elegido después de los primeros 30 días si su empleador no dispone de una MPN.

¿Qué es una red de proveedores médicos (MPN)?

Una MPN es un grupo selecto de proveedores de atención médica que tratan a trabajadores lesionados. Consulte a su empresa si utiliza una MPN. Si no ha nombrado a un médico antes de lesionarse y su empleador utiliza una MPN, acudirá a un médico de la MPN; después de su primera visita, es libre de elegir otro médico de la lista de la MPN.

¿Qué es la designación previa?

La designación previa es cuando nombra a su médico habitual para que lo trate si se lesiona en el trabajo. El médico debe ser doctor en medicina (Medical Doctor, MD), doctor en medicina osteopática (Doctor of Osteopathic Medicine, DO) o un grupo médico con un MD o DO. Debe nombrar a su médico por escrito antes de lesionarse o enfermarse; puede designar previamente a un médico si tiene cobertura de atención médica para lesiones y enfermedades no laborales. El médico debe:

- Haberlo tratado.
- Haber mantenido su historial y expedientes médicos antes de la lesión.
- Haber acordado tratarlo por una lesión o enfermedad relacionada con el trabajo antes de que se lesionara o enfermara.

Puede utilizar el formulario de "designación previa de médico personal" incluido en este folleto. Después de rellenar el formulario, no olvide entregárselo a su empleador; si su empleador no tiene una MPN aprobada, puede nombrar a su quiropráctico o acupunturista para que le trate las lesiones relacionadas con el trabajo. El aviso del quiropráctico o acupunturista personal debe hacerse por escrito antes de que se lesione. Puede utilizar el formulario incluido en este folleto; Después de rellenar el formulario, no olvide entregárselo a su empleador;

Con algunas excepciones, la ley estatal no permite que un quiropráctico siga siendo su médico tratante después de **24 consultas**. Una vez que haya recibido 24 consultas quiroprácticas, si sigue necesitando tratamiento médico, tendrá que elegir un nuevo médico que no sea quiropráctico. Por "consulta quiropráctica" se entiende cualquier visita a un consultorio quiropráctico, independientemente de que los servicios prestados impliquen manipulación quiropráctica o se limiten a evaluación y gestión.

Las excepciones a las 24 consultas incluyen las consultas de medicina física posquirúrgicas prescritas por el cirujano, o el médico designado por el cirujano, en virtud del componente posquirúrgico del Programa de Utilización de Tratamientos Médicos de la División de Compensación por Accidentes Laborales, o si su empleador ha autorizado consultas adicionales por escrito.

¿Y SI HAY ALGÚN PROBLEMA?

Si tiene alguna preocupación, dígalo. Hable con su empleador o con el administrador de reclamos que tramita su reclamo e intente resolver el problema; si esto no funciona, pida ayuda probando lo siguiente:

Póngase en contacto con la Unidad de Información y Asistencia (Information and Assistance, I&A) de la División de Compensación de Trabajadores (Division of Workers' Compensation, DWC). Las 24 oficinas de la DWC repartidas por todo el estado ofrecen información y asistencia sobre derechos, beneficios y obligaciones en virtud de las leyes de compensación por accidentes laborales de California. Los funcionarios de la I&A ayudan a resolver conflictos sin procedimientos formales. Su meta es conseguirle beneficios completos y a tiempo; sus servicios son gratuitos. Para ponerse en contacto con la Unidad de I&A más cercana, visite www.dir.ca.gov/dwc/ianda.html o llame al 1-800-736-7401.

La Unidad de I&A más cercana se encuentra en:
Dirección: _____

Número de teléfono: _____

Consulte con un abogado

La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar a un abogado, sus honorarios pueden deducirse de algunos de sus beneficios. Para obtener los nombres de los abogados de compensación por accidentes laborales, llame al Colegio de Abogados del Estado de California al 1-415-538-2120 o visite su sitio web en www.californiaspecialist.org. También puede obtener una lista de abogados en la Unidad de I&A local llamando al 1-800-736-7401.

Advertencia
Es posible que su empleador no le pague la compensación de trabajadores si se lesiona en una actividad recreative, social o deportiva voluntaria fuera del trabajo que no forme parte de sus obligaciones laborales.
Derechos adicionales
También puede tener otros derechos en virtud de la Ley federal de Americanos con Discapacidades (Americans with Disabilities Act, ADA) o la Ley de Justicia en el Empleo y la Vivienda (Fair Employment and Housing Act, FEHA) de California. Para obtener más información, póngase en contacto con el Departamento de Derechos Civiles (Civil Rights Department, CRD) de California, llamando al 1-800-884-1684 o con la Comisión para la lgualdad de Oportunidades en el Empleo (Equal Employment Opportunity Commission, EEOC), llamando al 1-800-669-4000.

La información contenida en este folleto se ajusta a los requisitos informativos que figuran en las secciones 3551 y 3553 del Código Laboral y en las secciones 9880 y 9883 del título 8 del Código de Reglamentos de California. Este documento ha sido aprobado por el director administrativo de la División de Compensación de Trabajadores.

Visite el sitio web de la División de Compensación de Trabajadores
www.dwc.ca.gov o llame al 1-800-736-7401
Departamento de Relaciones Industriales
1515 Clay Street, 17th Floor
Oakland, CA 94612

DESIGNACIÓN PREVIA DEL MÉDICO PERSONAL

En caso de que sufra una lesión o enfermedad relacionada con su empleo, podrá ser tratado de dicha lesión o enfermedad por su doctor en medicina (MD) personal, médico osteópata (DO) o grupo médico si:

- en la fecha de su accidente laboral tiene cobertura de atención médica por lesiones o enfermedades no relacionadas con el trabajo;
- el médico es su médico habitual, que será un médico que haya limitado su ejercicio de la medicina a la práctica general o que sea internista, pediatra, ginecólogo-obstetra o médico de familia colegiado o habilitado, y que haya dirigido previamente su tratamiento médico y conserve su historial médico;
- su "médico personal" puede ser un grupo médico si se trata de una sola corporación o sociedad compuesta por médicos licenciados en medicina u osteopatía, que gestiona un grupo médico multiespecialidad integrado que presta servicios médicos integrales predominantemente para enfermedades y lesiones no profesionales;
- antes de la lesión, su médico acepta tratarlo por lesiones o enfermedades laborales;
- antes de producirse la lesión, facilitó por escrito a su empleador la siguiente información: (1) aviso de que desea que su médico personal lo atienda por una lesión o enfermedad relacionada con el trabajo y (2) el nombre y la dirección profesional de su médico personal.

Puede utilizar este formulario para avisar a su empleador si desea que su médico personal o un médico osteópata lo atienda por una lesión o enfermedad relacionada con el trabajo y se cumplen los requisitos anteriores.

AVISO DE DESIGNACIÓN PREVIA DEL MÉDICO PERSONAL

Empleado: Complete esta sección.

Para _____ (nombre del empleador) Si tengo una lesión o enfermedad relacionada con el trabajo, elijo ser tratado por:

_____ (nombre del médico)
(M.D., D.O., o grupo médico)

_____ (dirección, ciudad, estado, código postal)

_____(Número de teléfono)

Nombre del empleado (en letra de imprenta): _____

Dirección del empleado: _____

Nombre de la compañía de seguros, plan o fondo que brinda cobertura de atención médica para lesiones o enfermedades no profesionales: _____

Firma del empleado _____Fecha: _____

Médico: Estoy de acuerdo con esta designación previa:

Firma: _____ Fecha: _____
(Médico o empleado designado del médico o grupo médico)

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado del médico o grupo médico no firma, se requerirá otra documentación del acuerdo del médico para ser predesignado de conformidad con el título 8 del Código de Reglamentos de California, sección 9780.1(a) (3).

Título 8 del Código de Reglamentos de California, sección 9783.

FORMULARIO DWC 9783 (jul 2014)

AVISO DE QUIROPRÁCTICO PERSONAL O ACUPUNTURISTA PERSONAL

Si su empleador o la aseguradora de su empleador no disponen de una red de proveedores médicos, es posible que pueda cambiar su médico tratante por su quiropráctico o acupunturista personal tras una lesión o enfermedad laboral. Para ser elegible para este cambio, debe comunicar por escrito a su empleador el nombre y la dirección profesional de un quiropráctico o acupunturista personal antes de la lesión o enfermedad. Por lo general, su administrador de reclamos tiene derecho a seleccionar a su médico tratante dentro de los primeros 30 días después de que su empleador tenga conocimiento de su lesión o enfermedad; después de que el administrador de reclamos haya iniciado su tratamiento con otro médico durante este periodo, podrá, previa solicitud, transferir su tratamiento a su quiropráctico o acupunturista personal.

NOTA: si su fecha de lesión es el 1.º de enero de 2004 o posterior, un quiropráctico no puede ser su médico tratante después de que haya recibido 24 consultas quiroprácticas, a menos que su empleador haya autorizado por escrito consultas adicionales. Por "consulta quiropráctica" se entiende cualquier visita a un consultorio quiropráctico, independientemente de que los servicios prestados impliquen manipulación quiropráctica o se limiten a evaluación y gestión. Una vez que haya recibido 24 consultas quiroprácticas, si sigue necesitando tratamiento médico, tendrá que elegir un nuevo médico que no sea quiropráctico. Esta prohibición no se aplicará a las consultas de medicina física posquirúrgica prescritas por el cirujano, o el médico designado por el cirujano, en virtud del componente posquirúrgico del Programa de Utilización de Tratamientos Médicos de la División de Compensación de trabajadores.

Puede utilizar este formulario para notificar a su empleador su quiropráctico o acupunturista personal.

Información sobre su quiropráctico o acupunturista:

_____

(nombre del quiropráctico o acupunturista)

_____

(dirección, ciudad, estado, código postal).

_____

(número de teléfono)

Nombre del empleado **(en letra de imprenta)**:

_____

dirección del empleado:

_____

Firma del empleado: _____ Fecha: _____

Título 8 del Código de Reglamentos de California, sección 9783.1.

(Formulario opcional DWC 9783.1 Fecha de entrada en vigor: 1.º de julio de 2014)

COLORADO RISK MODIFICATION PLANS

PREMIUM CREDIT FOR EMPLOYING PREVIOUSLY INJURED EMPLOYEES WITH PERMANENT PARTIAL DISABILITIES

Effective March1, 1993 Colorado Regulation 5-1-11 provides criteria for the modification of manual rates Workers Compensation.

One section of the Regulation provides for a premium credit for all employers who rehire injured employees.

The credit applies to the premium developed from the payroll of rehired injured employees who sustained permanent partial disabilities. (Does not apply to minimum premium policies.)

The Regulation defines a rehired employee with permanent partial disabilities as one "Who sustained permanent partial disabilities and is re-employed by the same employer, not a successor, at the pre-injury wages, including any wage increases to which such employee would have been entitled had the employee not been injured.

If any employee is rehired during a policy period the rehired employee shall be considered as being rehired for the total annual policy period or term.

If you have any employees who are in this category, please indicate the information below and return this to your agent or broker. Upon receipt of this information the payrolls will be verified at final audit and your policy will be adjusted to show any credit.

EMPLOYEE NAME	PAYROLL	POLICY PERIOD	DATE INJURED	DATE REHIRED	CLASS CODE

TOTAL NUMBER OF EMPLOYEES WHO SUSTAINED PERMANENT PARTIAL DISABILITIES (During the policy term) _____

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

Workers Compensation
Acknowledgement Form:

POLICY NUMBER: UB-1T152983-25-14-G

POLICY EFFECTIVE DATE: 02-15-25

IMPORTANT MESSAGE TO INSUREDS

ACKNOWLEDGEMENT FORM REQUIREMENTS

Dear Insured:

Colorado Insurance Regulation 5-1-11, Risk Modification Plans, allows premium credits to employers who have IMPLEMENTED Certified Workers Compensation Risk Management Programs.

Premium credits for eligible employers are to be applied by the attachment of endorsement WC 05 04 03 (00) to the policy. The Colorado Workers Compensation Cost Containment Board has determined that a premium differential shall be provided on all policies when you have selected a Designated Medical Provider.

In order to obtain the premium credit you – the Employer – must complete and sign the bottom portion of this form with the requested information. Retain a copy for your records and send your agent or producer a copy. Your agent or producer will forward a copy to your Insurer. An endorsement, will then be attached to your policy to reflect the credit.

For a complete explanation of how these programs operate and the savings, please contact your agent or producer.

☐ **I have implemented a Certified Workers Compensation Risk Management Program****

☐ I have NOT implemented a Certified Workers Compensation Risk Management Program

☐ **I have selected a Designated Medical Provider**

PROVIDER: _____

☐ I have NOT selected a Designated Medical Provider.

** A copy of your Workers Compensation **Colorado Premium Cost Containment Certificate** must be forwarded to your Insurer.

Date: _____ Employer: _____

Name: _____

Title: _____

Signature: _____

IMPORTANT NOTICE

TO ALL COMMERCIAL CASUALTY AND/OR COMMERCIAL PROPERTY POLICYHOLDERS DOING BUSINESS IN THE STATE OF FLORIDA

Florida loss control insurance statutes require insurers to provide commercial policyholders, at their request, with guidelines for risk management plans. Travelers Risk Control Department has available guidelines to assist you with your accident prevention activities. These guidelines are available to you free of charge.

The risk management program shall include safety measures, including, as applicable, pollution and environmental hazards, disease hazards, accidental occurrences, fire hazards and fire prevention and detection, liability for acts from the course of business, slip and fall hazards, product injury, and hazards unique to a particular class or category of insureds.

Training in safety management techniques and safety management counseling services are also available.

If you would like to request assistance with risk management or your safety program, please call our Risk Control department at 800-973-9215. For access to over 1,000 safety and health resources, including training programs, checklists, management guides, etc., log in at www.travelers.com. Not registered? Select "Log In" and then "Register Now" to register for MyTravelers for Business.

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS – EMPLOYER FACTS

Your workers' compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers' compensation system.

Workers' Compensation Notice

The law requires that every employer who has secured workers' compensation coverage post in conspicuous place(s) a notice that contains the employer's insurance carrier information, the expiration date of the policy and an anti-fraud statement. The Division of Workers' Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers' compensation policies, they shall be deemed to have failed to secure workers' compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll.
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers' compensation coverage or fail to update information on their workers' compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employer within three business days. You can also fill out the First Report of Injury or Illness form (DWC-10) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-413-1980. To access the form, go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee's work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the injury or illness.
- Provide a one-time change of physician within five business days of receipt of your written request.

Authorized treatment and care may include:

- Doctor's visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expense to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a $10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee's injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eight day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- Temporary Total Benefits. These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits. These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- Permanent Impairment Benefits. These benefits are provided when the injury causes any physical psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a while. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits. These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits. Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits 9each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWS-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call you workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/WC/organization/eao_offices.html.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to $25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

Workers Compensation Exemptions

Construction Industry

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers' compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10-percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be except. A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed on the exemption is revoked by the Division.

Non-Construction Industry

An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers' compensation coverage.

Sole proprietors and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division's Bureau of Compliance at (850) 413-1609 or go to http://www.MyFloridaCFO.com/WC/forms.html and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

What Your Employee Can Expect From the Insurance Carrier

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of the employee's claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of the employee's claim. This information should be provided to the injured worker by mail on either a Notice of Action/Change form (DWC-4) or a Notice of Denial form (DWC-12)

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/wc where you will find extensive information such as publication, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline

1-800-342-1741

Injured worker e-mail inquiries

wceao@MyFloridaCFO.com

Customer Service

(850) 413-1601

Employer e-mail inquires

WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline

1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work related injuries or illnesses occur. By law, however, employees are required to report work related injuries or illnesses within 30 days.

Q) To whom should I report the work-related injury?

A) You should report the accident to your insurance company y as soon as you have knowledge of the injury. By law, you have seven days from your first knowledge of the work related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illnesses?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers' compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers' compensation carrier's responsibility to investigate all claims and determine if employees are entitled to benefits under Florida's Workers' Compensation Law.

Q) Does the employee pay any part of my workers' compensation insurance premium?

A) No. The law is very specific on this point. It is the employer's responsibility to pay the entire premium for workers' compensation.

Employers who secure workers' compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-free Workplace Program, please call the Division of Workers' Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers' compensation claims?

A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employee should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

Disclaimer:

This publication is being offered as an informational tool only and complies with s.440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 39L-3.025, F.A.C. Forms
DFS-F2-DWC-65
Revised March 2010

INFORMATIÓN IMPORTANTE DEL SEGUOR DE INDEMNIZATION POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA – INFORMATIÓN PARA EMPLEADORES

Su póliza de seguro por accidents de trabajo curbre beneficios médicos y reemploazo parcial del salario para cualquier empleado que sostenga lesion o una enfermedad relacionada con su trabajo.

Este folleto le dará una major comprensión de su papel y responsabilidades bajo el Sistema de seguro por accidents de trabajo.

Aviso de seguor por accidents de trabajo

La ley require qua cada empleador que ha adquirido una póliza de seguro por accidents de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañia de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La Division de Compensaction por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañies de seguro se las proporcionen a sus asequrados. Su compania de seguros tiene obligation legal de proveerle los cartels.

Aunque el empleador adquiera una póliza de seguros por accidents de trabajo, se consideran no haberlo hecho si han cometido cualquiera de las siguiente acciones:

- Subestimar u ocultar nómina de pago.
- Falsificar u ocultara las responsabilidades del empleado para evitar la classificación apropriada para los calculus de la prima de seguro
- Falsificar u ocultar información pertinente al cálculo y aplicación de un factor de modificación de experiencia

Los empleadores que tienen obligación de proveer seguro por accidents de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidents de trabajo, son sujetos, a recibit una orden de suspension de trabajo y penas civiles y criminals.

Primer reporte de la lesion o enfermedad

Tan pronto usted se entere de una lesion o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañia de seguro por accidents de trabajo. Si usted no reporta la lesion o la enfermedad a la compañia de seguro en un plazo de siete dias despues de la fecha que usted fue informado, usted puede estar sujeto a una multa administrative que no exceda $2,000 por ocurrencia. La mayoría de las companies de seguros tienen un número gratis para reporter lesions relacionadas con el trabajo. Si usted reporta la lesion o la enfermedad a la compañia de seguros por teléfono, la compañia de seguros llenará el formulario y le enviará una copia al empleado debtor de tres dias laborales. Usted también puede completer el primer reporte de la lesion o enferemedad (DWC-1) y enviarlo a la compañia de sequros. El formulario contiene información sobre el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en al formulario, pero si el empleado no puede o no esta disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reporter muertas que resulten por lesions o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reporter una fatalidad en el lugar de trabajo, llame al 1-800-219-8953 (en la Florida) o al 850-413-1611, o envie el primer reporte de la lesión o enfermedad con la información sobre la muerte por fax a 850-413-1980. Para tener acceso al formulario, vaya a la página web http://www.MyFloridaCFO.com/WC/forms.html. Haga clic en DWC-1.

Beneficios médicos

Tan pronto usted le notifique a la compañia de seguro sobre la lesión que sufrió su empleado en el trabajo, la compañia:

- Determinará si la lesión es compensable

- Proveerá un medico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

- Consultas medicos
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de ida y vuelta por viajes a consultas médicas o farmacias autorizadas.

En cuanto usted alcance la máxima mejoría médica (MMI por su sigla en Inglés) usted tendrá que pagar un copago de $10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el medico que lo (a) atiende determina que la lesión o enfermedad del empleado se ha curado al grado que mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualaran a dos tercios (2/3) del salario seminal regular del empleado antes de sufrir la lesion o enfermedad, pero el beneficio no excederá el promedio de los salaries semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañia de seguros se entere de la lesión o enfermadad. Los siguientes cheques se le enviaran cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclama y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en Inglés): Estos beneficios son proveidos como resultado de una lesión o enfermedad que temporalmente prohibe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la maxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en Inglés): Estos beneficios son proveldos cuando el médico le permite al empleado volver a trabajar, el empleado no ha alcanzado la maxima mejoría médica, y gana menos del 80% del salrio que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión. El period máximo que el empleado lesionado puede recibir beneficios temporalis es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero..
- Beneficios por daños permanente (IB por su sigla en Inglés) Estos beneficios son proveldos cuando la lesión o enfermedad causa cualquier pérdida fisica, psicológica o functional y el impedimento existe después de la fecha de la maxima mejoría médica (MMI). Un médico asignará una valoración de incapacidad permanente a la lesión que sera expresada como un porcentaje.
- Beneficios por incapacidad total permanente (PTD por su sigla en Inglés): Estos beneficios son proveidos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley .
- Indemnizaciones por fallecimiento: Compensación por accidents de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a limites definidos por ley). Un cónyuge dependiente puede sere legible para entrenamiento vocacional.

Formulario de la declaración del salario

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWS-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañia de sequros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario al despedir o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (http://www.MyFloridaCFO.com/WC/forms.html) y haga clic en DWC-1a.

Oficina de ayuda al trabajador

Si usted tiene algunas preguntas o preocupaciones sobre los beneficios que ofrece el seguro por accidents de trabajo, llame a su compañia de seguros. Si la compañia de seguros no ofrece la información que used ha pedido, usted puede llamar la División de Compensación, por Accidentes de Trabajo, oficina de Ayuda al Empleado (EAO) al 1-800-342-1741. Esta oficina ayuda a prevenir y a resolver disputas entre los trabajadores y los empleadores/las companies de seguros.

Los especialistas de la EAO poseen conocimiento sobre el Sistema de seguro por accidents de trabajo y pueden contester sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitor. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, "Preguntas heches con frecuencia por empleadores," que puede alcanzar en: http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petición para beneficios

Para comenzar el proceso judicial para solicitor beneficios que se le deben según la ley pero la compañia de seguros no lo ha proveldo, se debe presenter el formulario "Petition for Benefits" [Petición para beneficios] a la Oficina de Los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/forms.asp.

Programa de recompensación contra fraude

El fraude en el seguro por accidents de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañia de seguros, presenta información falsa o engañosa. El fraude del seguro por accidents de trabajo as un delito mayor de tercer grada que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se les puede pagar a personas quienes proven información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0455 para reporter sospechas de fraude de sequros por accidents de trabajo.

Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada complete o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidents de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) de una corporación en la industria de la construcción pueden elegir ser exentros si:

- Poseen un minimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que de testimonio a la propiedad del 10 por ciento minima.
- El official de la compañia aparece como official de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece active en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elige ser exentos. Se require pagar $50 por cada aplicación presentada para obtener una extension. Exenciones en las industrias que participant en la construcción son validas por dos años o hasta que se register una revocación voluntaria o si la exención es revocada por la división.

Industrias que no se dedican a la construcción

Un empleado que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada complete o jornada parcial tiene que obtener la cobertura de sequros por accidents de trabajo.

Proprietaries únicos y socios en industrias que no participant en la construcción están automáticamente exentos de la ley, pero pueden elegir ser cubierto.

Oficiales de una coporación que no se dedica a la construcción puede elegir ser exentos si:

- El official esta listado como official de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación esta listada active en el registro del Departamento del Estado de la Florida, División de Corporaciones.

No hay limite de oficiales que pueden ser elegibles para ser extentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son validas por dos años o hasta que se registra una revocación voluntaria o si la exención es revocada por la división.

Para consequir copias de la notificación de elección para ser exento (en Inglés Notice of Election to Be Exempt) llame al (850) 413-1609 o vaya a nuestro sitio Web en http://www.MyFloridaCFO.com/WC/forms.html, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

Lo que su empleado puede esperar de parte de la compañia de seguros:

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago opotuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será proveida por correo en un formulario titulado "Notice of Action/Change" (DWC-4) [Notificación de Acción o Cambio (DWC-4)] "Notice of Denial" (DWC-12) [Notificación de Negación (DWC-12)].

¿Tiene preguntas sobre el seguro por accidents de trabajo?

Por favor, visite nuestra página Web en www.MyFloridaCFO.com/wc donde usted encontrará información extensa tal como publicaciones, un número de bases de datos, reglas, y formas que le dará un major entendimiento del seguro para accidents de trabajo

Oficina de Ayuda el Trabajador (Oficina de asistencia para el trabajador 1-800-342-1741

Empleados lesionados pueden hacer preguntas por correo electrónico wceao@MyFloridaCFO.com

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico

WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude

1-800-378-0445

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reporter lesions u enfermedades relacionadas con el trabajo?

R) Los patrones deben aconsejar a sus empleados que reporten accidents tan pronto como ocurren lesions o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se require que empleados reporten lesions o las enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reporter la lesión relacionada con el trabajo?

R) Usted debe reporter el accidente a su compañia de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Teno que reporter un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Si. Usted debe reporter todas las demandas de lesions o de enfermedad relacionadas con el trabajo a su compañia de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesions u de las enfermedades. Es responsabilidad de la compañia de seguros por accidents de trabajo investigar todas las demandas y determiner si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidents de trabajo..

P) ¿El empleado paga parte de la prima de seguor por accidents de trabajo?

R) No. La ley es muy especifica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro por accidents de trabajo.

Empleadores que adquieran una póliza de seguros por accidents de trabajo pueden también aplicar para ser un lugar de trabajo libre de drogas y pueden recibir un descuento de prima. Para aprender más sobre el programa, llame por favor a la División de Compensación por Accidentes, la oficina del servicio de atención al cliente al 850-413-1609.

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respect a sus reclamaciónes?

R) Usted debe primero contactar a su compañia de seguros. Si la aseguradora no puede contester la pregunta o resolver el problema, usted o sus empleados deben llamar la oficina de la ayuda al Trabajador en at 1-800-342-1741.

Limitación de responsabilidad

Esta publicación esta siendo ofrecida solo como una herramienta de información, acata s.440.185 (4) F.S., con el entendimiento que esto no es lenguaje official de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación or accidents de trabajo responsible de daños directos o resultants del uso de ese material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 39L-3.025, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010

IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA

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

Please review your policy carefully. Should you have any questions concerning coverages, billings, additions or deletion, please contact your agent. Should you feel the need for additional information or wish to make a complaint, we offer the following number:

For information or to make a complaint, call
1-800-328-2189

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: UB-1T152983-25-14-G Effective Date of Policy: 02-15-25

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventive maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s.775.083 or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Certification of Employer Workplace Safety Program Premium Credit, and that the facts stated in it are true.

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone No.: ( ) _____

C. Address: _____

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

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

_____	_____	_____
Employer Name	**Date**	**Officer/Owner Signature***

_____

Title

***Application must be signed by an officer or owner.**

IMPORTANT NOTICE - QUARTERLY REPORTING AND SELF-AUDIT REQUIREMENTS - FLORIDA

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

As a reminder, Florida Workers Compensation Department requires that you file an Employer's Quarterly Tax Report (RT-6) with the Florida Department of Revenue. Pursuant to Florida Workers Compensation Law Section 440.381(4), the Florida Workers Compensation Department now requires that you also provide us, as your insurance carrier, with a copy of your **Employer's Quarterly Earnings Reports (RT-6)** and **Self-audits.**

You must submit to us a copy of your Quarterly Earnings Report at the end of **each quarter** per the following schedule:

QUARTER ENDING	DUE DATE
March 31	May 10
June 30	August 10
September 30	November 10
December 31	February 10

The self-audits must be supported by the quarterly earnings reports required by Florida Statute Chapter 443 (Reemployment Assistance).

The reports must include a sworn statement by your officer or principal attesting to the accuracy of the information contained in the report.

The reports should be mailed to Travelers, Attn: Premium Audit, PO Box 2927, Hartford, CT 06104-2927. Should you have any questions regarding this notice, please contact your Agent or Broker.

IMPORTANT NOTICE – COMPLAINTS – ILLINOIS

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

If you are having problems you may contact your insurance agent directly or you may contact the company at:

Mail: Consumer Affairs
One Tower Square
Hartford, CT 06183

Phone: (860) 277-1561 or toll free (866) 894-0687

Email: consumeraffairs@travelers.com

The addresses and phone numbers of the consumer complaint division of the Illinois Department of Insurance are:

Illinois Department of Insurance
Consumer Division
122 S. Michigan Ave. – 19th Floor
Chicago, IL 60603
312-814-2420 phone

And

Illinois Department of Insurance
Consumer Division
320 W Washington St
Springfield, IL 62767
217-782-4515 phone

Complaints may also be filed electronically to the Illinois Department of Insurance at:

https://mc.insurance.illinois.gov/messagecenter.nsf

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

IMPORTANT NOTICE

RELIGIOUS FREEDOM PROTECTION AND CIVIL UNION ACT – ILLINOIS

The Illinois Religious Freedom Protection and Civil Union Act provides that persons of the same or opposite sex who enter into a civil union must be afforded the same obligations, protections, and legal rights as married persons. This law became effective June 1, 2011, and is designed to ensure that civil unions and marriage are treated identically under Illinois law. In accordance with law, this policy will be interpreted to provide the same benefits and protections to persons in a civil union or in a marriage.

IMPORTANT NOTICE – FILING COMPLAINTS WITH THE INDIANA DEPARTMENT OF INSURANCE – IN

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

Questions regarding your policy or coverage should be directed to:

Travelers

(800) 328-2189

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

IMPORTANT NOTICE – SOLE PROPRIETORS, PARTNERS, LIMITED LIABILITY COMPANY MEMBERS AND LIMITED LIABILITY PARTNERS – IOWA

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

In the state of Iowa, sole proprietors, partners, limited liability company members and limited liability partners are not automatically covered by the workers compensation laws of the state unless they purchase valid coverage that specifically endorses that person on to the policy.

If you are a sole proprietor or have partners, limited liability company members or limited liability partners who elect to remain excluded from workers compensation coverage, **the state of Iowa mandates that the nonelection form be completed online at https://www.iowaworkcomp.gov/nonelection–workers–compensation–or–employers–liability–coverage.**

Workers Compensation Information for Kansas Employers and Employees

The mandated Posting Notice (K-WC 40-A) and other Workers Compensation forms are available to download at www.dol.ks.gov.

For additional information on workers compensation benefits, employer guidelines and other general information, contact:

Kansas Department of Labor
Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603-3105
(785) 296-4000
(800) 332-0353
Email: kdol.wc@ks.gov
Website: www.dol.ks.gov

Follow us:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

For more information on workers compensation insurance rates and insurance carrier conduct, contact:

Kansas Department of Insurance
1300 SW Arrowhead Rd.
Topeka, Kansas 66604
(785) 296-3071
(800) 432-2484
Email: kid commissioner@ks.gov
Website: www.insurance.kansas.gov

Table of Contents

What is Workers Compensation?

Workers compensation is a required insurance plan provided by the employer to pay employee benefits for job-related injuries, disability or death that arise out of and in the course of employment.

Per K.S.A. 44-508, an injury by accident shall be deemed to arise out of employment if:

- There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
- The accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment.

The words "arising out of and in the course of employment" as used in the Workers Compensation Act shall not be construed to include:

- Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;
- accident or injury which arose out of a neutral risk with no particular employment or personal character;
- accident or injury which arose out of a risk personal to the worker; or
- accident or injury which arose either directly or indirectly from idiopathic causes.

Benefits are paid at the employer's expense. Coverage begins the first day on the job.

The present law covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of $20,000 or less. All payroll is taken into account, including that paid in Kansas or elsewhere. If the employer is a sole proprietor or a partnership, the wages paid to the owners and any of their family members are not used in the computation of the gross annual payroll. Per K.A.R. 51-11-6, the provision in K.S.A. 44-505 excluding the payroll of workers who are members of the employer's family shall not apply to corporate employers. A corporate employer's payroll for purposes of determining whether the employer is subject to the workers compensation act shall be determined by the total amount of payroll paid to all corporate employees even when a corporate employee has elected out of the workers compensation act pursuant to K.S.A. 44-543.

Employees who are disabled due to a job-related injury or disease are entitled to:

- medical expenses to treat the job-related injury or illness; and
- income benefits to replace part of the wages lost due to disability.

If death results from a job-related injury or disease, benefits may be paid to the surviving spouse, dependents or heirs.

Purpose of the Law

Kansas passed its first workers compensation law in 1911. By regulating litigation and benefits, the law is designed to protect the interests of both employers and employees. Employers benefit by substituting a known expense (premiums) for the risk of large, unbudgeted expenses in the event of serious employee disabilities. Employees benefit because negligence of the employer is not an issue in determining liability. Workers compensation coverage is a no-fault system. The provisions of the Workers Compensation Act shall be applied impartially to both employers and employees. While initially aimed at hazardous jobs, the law now covers most workers.

Elections

Elections in or out of the Workers Compensation Act are options available to employers or employees. Depending on the circumstances, options may be available for:

- non-covered employers – e.g., those with payrolls of $20,000 or less or in certain agricultural pursuits;
- corporate employees owning 10 percent or more of stock;
- individuals, proprietors or partnerships;
- employers seeking coverage for volunteers and other non-covered workers; and
- volunteer directors, officers or trustees of a nonprofit organization.

Example: A two-person partnership has two employees – a family member and a non-family member – and an annual payroll of $15,000. The partnership may elect to purchase coverage under the Act and to extend such coverage to both employees. The partners are not covered because they are considered to be the employer.

Elections may be filed online at www.oscar.dol.ks.gov.

Employee Rights and Responsibilities

Kansas law protects an employee's right and ease in obtaining workers compensation. Specifically:

- An employee cannot be fired, demoted or otherwise discriminated against for filing a claim in good faith.
- Employees must be informed of their rights and responsibilities in case of injury. In the event of employee death, such information must be furnished to the employee's beneficiaries.
- Employees must not be charged for the payment of workers compensation claims. Employers cannot deduct from pay or benefits to pay insurance premiums or claims.
- Employees may be entitled to compensation benefits from an employer subject to the Act regardless of insurance coverage.
- Employees may obtain free assistance by contacting the Workers Compensation Ombudsman's office at (800) 332-0353 or (785) 296-4000.
- The law provides specific penalties for employee or employer fraud in workers compensation cases. For assistance or more information, or to report suspected fraud, contact the Workers Compensation Ombudsman or the Fraud and Abuse office at (800) 332-0353 or (785) 296-4000.

Employer Responsibilities

Workers Compensation Insurance

Most employers are required by law to provide for the payment of workers compensation claims, at no expense to the employee. Employers shall satisfy this requirement in one of three ways:

- **Workers compensation insurance:** obtained from a licensed insurance carrier; the employer pays the premiums and the insurance company pays the claims. The insurance carriers are regulated by the Kansas Insurance Department.
- **Self-insurance:** an individual employer must demonstrate to the State the financial ability to pay any claims that might arise. This program is administered by the Division of Workers Compensation.
- **Group-funded pool:** a group of employers meeting certain statutory requirements may form a self-insurance program to jointly insure their ability to pay claims. This program is administered by the Kansas Department of Insurance.

Intentional failure to provide for workers compensation payment in one of the above ways is a **class A misdemeanor** and subjects the employer to a civil penalty in an amount twice the annual premium the employer would have paid for insurance or $25,000, whichever amount is greater.

Employment categories excluded from the law are:

- certain agricultural pursuits;
- realtors who qualify as independent contractors;
- employers with gross annual payrolls of $20,000 or less;
- firefighters belonging to a firefighters relief association which has waived coverage under the workers compensation law; and
- certain owner-operator vehicle drivers covered by their own occupational accident insurance policy.

OTHER REQUIREMENTS

- Employers must post written notice K-WC 40-A advising employees what to do in case of injury.
- Per K.S.A. 44-557, "it is...the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained."

  As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

- **Immediately upon learning of an employee's injury or death, the employer must furnish written information to the employee or employee's dependents on available benefits, the claims process, an employer or insurance company contact for workers compensation claims, and other matters as required by law.** Use forms K-WC 27-A (English) and K-WC 270-A (Spanish) for reporting.
- An insurer or self-insured employer shall provide the following notice to an insured worker on or with the first check for temporary disability benefits: *Warning: Acceptance of employment with a different employer that requires the performance of activities you have stated you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in loss of future benefits and restitution of prior workers compensation awards and benefits paid* .

If you need assistance, call (800) 332-0353 or (785) 296-4000.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014, is outlined in K.A.R. 51-9-17.

Categories of Disability Benefits

Temporary Total Disability

Exists when the employee, on account of injury, is unable to engage in any type of substantial and gainful employment. Benefits are paid for the duration of the temporary total disability (TTD). There is a one- week waiting period (seven calendar days) before TTD benefits are paid. If the disability continues for three consecutive weeks, the employee is reimbursed for the waiting period. Employees may collect medical benefits during the first week. Benefits are 66 2/3 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum. Temporary total compensation may not exceed $130,000 per injury.

Employees may **not** collect temporary total disability and unemployment benefits for the same weeks.

Temporary Partial Disability

Exists when the worker returns to any employment at a wage less than the time of injury wage. Compensation is calculated on a weekly basis and is paid until the wage loss is no longer present or the benefit maximum is reached, whichever comes first.

Benefits are 66 2/3 percent of the difference between the employee's average gross weekly wage before the injury and the employee's wage after the injury. Benefits may not exceed the state's statutory maximum.

Permanent Partial Scheduled Disability

Exists when there is complete or partial loss of or loss of use of a body part, such as an arm, due to a job-related injury. Compensation for permanent partial scheduled disability is limited to a percentage of the following schedule. A healing period is available in cases of amputation. Benefits are 66 2/3 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum cap of $130,000.

Benefit Information Schedule

Loss of or loss of use of:	Weeks Paid:	Loss of or loss of use of:	Weeks Paid:
Shoulder 225	225	Thumb	60
Arm 210	210	1st (index) finger	37
Forearm 200	200	2nd (middle) finger	30
Hand150	150	3rd (ring) finger	20
Leg 200	200	4th (little) finger	15
Lower leg 190	190	Great toe	30
Foot 125	125	Great toe, end joint	15
Eye 120	120	Each other toe	10
Hearing, both ears 110	110	Each other toe, end joint only	5
Hearing, one ear30	30		

Permanent Partial General Disability

Exists when a worker is disabled in a manner which is partial in character and permanent in quality, and which is not covered by the schedule above. For example, disability involving the back or the loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity; or the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or foot of the other lower extremity; or the loss of or loss of use of both eyes which is partial in character and permanent in quality are whole body disabilities and are not covered by the above schedule. Compensation for such "non-scheduled" or "whole body" disability is based on the greater of the following: the percentage of functional impairment; or, the employee's reduced ability to perform work tasks and the average weekly wage the employee is capable of earning after the injury. Employees earning 90 percent of pre-injury wage are limited to functional impairment.

Calculating Permanent Partial General Disability Benefits

1. **Calculate weekly benefit rate by identifying the smaller of these two amounts:** Gross average weekly wage x 66 2/3 percent; or the statutory maximum.

2. **Calculate allowable weeks of compensation:** Begin with 415 weeks. Subtract from 415 the number of weeks of temporary total disability paid, excluding the first 15 weeks of such temporary total paid. Multiply the difference by the percentage of disability.

3. **Calculate total benefits:** Multiply weekly benefit rate by allowable weeks of compensation.

Example: Average weekly wage is $875 at date of accident (*7/10/2011*). Employee has collected 25 weeks of temporary total disability and has a 25 percent disability rating.

Weekly benefit rate: (use lesser amount)

$875 x .6667 = $583.36

statutory maximum (*as of 7/1/11*) $555

Allowable weeks of compensation:

415 - [25-15] = 415 - 10 = 405 weeks
405 weeks x .25 = 101.25 weeks

Maximum benefit amount:

101.25 weeks x $555 = $56,193.75

Our website has a Workers Compensation Calculation Program. The date program allows you to calculate time between two dates or to calculate the addition of days to a known date. The scheduled injury and whole body injury programs will allow you to compute the compensation benefits due to the claimant. Step-by-step instructions are provided for each program.

Permanent Total Disability

Exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, both legs or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall also constitute permanent total disability.

Benefits are 66 2/3 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum. Total compensation may not exceed $155,000 per injury.
An employee is not allowed to receive more than one award of permanent total disability in a lifetime.

How Rates are Determined

Workers compensation insurance in Kansas is mandated by state law for most but not all employers. The premiums paid by the employers should be sufficient to cover the claims incurred by their insurance companies. Rates are adjusted based on the most recent premiums, investment income and losses reported by the insurance companies. The National Council on Compensation Insurance (NCCI) submits these rates annually to the insurance commissioner for approval.

The NCCI is a ratemaking organization, licensed by the Insurance Department, whose membership is primarily comprised of insurance companies. They develop the annual rate change needed based on the losses and premium reported to them by their member insurance companies.

The Kansas Insurance Department regulates the rates charged in Kansas. Each year, the Insurance Department reviews premiums, claims costs and other relevant data submitted by the NCCI to determine whether a rate change is supported. Currently, about 70 cents of every $1 collected in premiums is projected to cover the cost of paying workers compensation claims. Approximately 27.5 percent of each dollar is used by insurance carriers to cover other costs of doing business – e.g., administrative expenses, salaries and overhead. The margin of profit is projected at roughly 2.5 percent plus the earnings on investments.

After reviewing the rate filing, the commissioner of insurance generally approves an "overall" statewide premium change. This "overall" change is stated as a percentage (for example, a five percent overall increase); however, individual classification base rates may increase or decrease more than the "overall" change.
Individual classification base rates must continue to reflect the experience (premiums and losses) of employers in each classification.

Premium Components

Workers compensation insurance premiums are calculated based on several factors. The primary factors are:

Base rate: the starting point in calculating premiums. The base rate or loss cost is filed by NCCI and all carriers are required to use it. The base rates can change annually due to statewide loss experience of all employers in the same classification. The companies multiply the base rate by their approved Loss Cost Multiplier (LCM) in order to determine the rate per $100 of payroll.

Classification: a key factor in determining what rate an employer will pay. Classification denotes the employer's type of business; hazardous jobs are more likely to result in substantial and costly claims and, therefore, usually have a higher rate. There are about 600 classifications in use in Kansas.

Experience rating: affects premium based on the frequency and severity of compensation claims of employers with sufficient premium size to be "experience rated." Currently, employers with an annual premium of at least $4,500 within the past two years, or if more than two years, an average annual premium of $2,250 or more are experience rated. Fewer and less expensive claims mean a lower experience modification factor, which means a lower premium.

Payroll size: employers with larger payrolls generate more workers compensation annual premiums than those with a smaller payroll in the same classification. However, the expenses incurred in issuing and servicing the policy do not increase in direct proportion to the policy premium. Consequently, a premium discount may be applied to policies with a larger premium to recognize this factor.

Also, some employers are subject to fixed payroll amounts. Partners, sole proprietors and members of a limited liability company who elect to cover themselves under a workers compensation insurance policy pay a premium based on a set payroll which is adjusted annually. The premium for an executive officer of a corporation is based on the actual payroll of the officer, subject to a set per-week minimum and maximum payroll which may be adjusted annually.

Factors Affecting Premiums

Three of the most important factors in reducing premiums are:

1. **Implementation of an accident prevention program:** these programs were mandated by 1993 legislation and are to be made available to employers by all insurance carriers and group-funded pools operating in Kansas. Because accident prevention programs have been shown to reduce the frequency and severity of injuries, they offer employers the potential to reduce premiums. Premium reduction is, of course, only one benefit of accident prevention that employers should consider.
2. **Assuring the proper classification(s) was used to calculate the premium:** the classification used on the policy should, as reasonably and accurately as possible, describe the employer's business and the employee's duties. The use of an inappropriate classification could result in the payment of an incorrect premium. If a classification does not seem to accurately describe a particular job, assistance in verifying that the proper classification was used or in obtaining a correction is available by calling the Insurance Department: (800) 432-2484 or (785) 296-3071, or visiting the website at www:insurance.kansas.gov
3. **Use of deductible:** deductibles can be a cost-effective means of reducing premiums and are available in various amounts. Losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification. The insurer shall pay the deductible amount and seek reimbursement from the insured employer for the applicable deductible amount.

General Information

How to Obtain Insurance

Workers compensation insurance coverage can be obtained by:

- contacting a licensed insurance agent;
- contacting the Kansas Insurance Department for information on group-funded pools; or
- contacting the Division of Workers Compensation for information on self-insurance.

Kansas Workers Compensation Insurance Plan (Assigned Risk Plan)

Any employer who is in good faith entitled to but unable to purchase coverage in the voluntary workers compensation insurance market can obtain coverage in the Assigned Risk Plan. This means an employer is assigned to an insurance carrier who is authorized to provide coverage. Assigned Risk Plan premiums are calculated using the same loss costs as if the coverage were purchased in the voluntary market; however, premiums may be higher due to differentials applied to assigned risk rates and individual employer loss experience.

For assistance and questions about the Assigned Risk Plan, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Insurance Rating Appeals Process

If an employer suspects the wrong classification or other incorrect factor is being used in calculating a premium, the rating may be appealed in writing to the insurance carrier from which the coverage was purchased. The employer may also appeal in writing to the Kansas Commissioner of Insurance by outlining the nature of the complaint or appeal.

For additional information, or for assistance in appealing or correcting a classification error or other rate problem, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Division of Responsibilities

Responsibilities of the Employee:

- Notify your employer immediately. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
  - 20 calendar days from the date of accident or the date of injury by repetitive trauma;
  - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
  - 10 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.
- Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.
- The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the Workers Compensation Act or has suffered a work-related injury.

Responsibilities of the Employer:

- Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.
- Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

  As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 standards. For details contact Techs and Stats, Division of Workers Compensation at 785-296-4000 or 800-332-0353. You may access our website at http://www.dol.ks.gov/WorkComp/edinews.aspx.
- **The employer is required** by K.S.A. 44-5,102(a) to deliver information immediately to employee or legal beneficiary to assist in the claims process (material is available from the employer's carrier or the Division of Workers Compensation), including form K-WC 27-A or K-WC 270-A (Spanish).

Responsibilities of the Division of Workers Compensation:

- Makes official record of accident reports filed with the division.

Survivors' Benefits

The workers compensation law provides for survivors' benefits in the event of an employee's job-related death. Survivors do not need to be U.S. citizens or reside in the United States to receive compensation.

The weekly benefits are based on 66 2/3 percent of the employee's average weekly wage at the time of the accident or injury, but cannot exceed the statutory **maximum**. The **minimum** death benefit is 50 percent of the state's average weekly wage in effect on the date of accident. Total compensation benefits may not exceed $300,000, unless benefits are being paid to a dependent child under the age of 18. Funeral expenses up to $10,000 and all medical and hospital expenses related to the fatal injury are also covered.

An initial payment of $60,000 must be made to the surviving legal spouse or wholly dependent child(ren) or divided among them, 50 percent to the surviving legal spouse and 50 percent to the dependent children. This $60,000 payment is not subject to the eight percent discount normally allowed for lump sum payments. The initial payment shall be paid immediately.

Spouse and Children

If an employee is survived by a spouse but no dependent children, the spouse receives the entire weekly benefit. If an employee is survived by a spouse and children, the weekly benefit is paid half to the spouse and half to the children. If an employee is survived only by children, the weekly benefit is divided equally among the children.

Dependent children receive benefits until age 18, or until age 23 if they are full-time students or mentally or physically disabled, even if the benefits exceed the statutory limit at the time of the accident. Where required, the employer shall pay the costs of a court appointed conservator not to exceed $2,500.

Other Dependents

If survivors' benefits are paid to the spouse and/or children, they may not be paid to any other beneficiaries. In the case of unmarried employees leaving no dependent children, any other dependents who were wholly or partially dependent upon the employee may receive compensation.

Dependents other than spouse or children may collect weekly benefits subject to the statutory provisions, until they die, remarry or receive more than 50 percent of their support from another source.

Legal Heirs

If the employee leaves no spouse, dependent children or other dependents either wholly or partially dependent upon the employee, a lump sum payment of $100,000 shall be made to the legal heirs of the employee, subject to reductions based on employer procured life insurance.

Conditions Affecting Benefits

Drugs and Alcohol

An employer is not liable for workers compensation benefits if an employee is impaired due to the use of alcohol* or drugs** and the impairment contributed to injury or death. This includes the use of prescription or non-prescription medications; benefits may be allowed, however, if:

- the drugs or medications were taken in therapeutic doses; and
- the employee had not been impaired on the job from such medications within the past 24 months.

If it is shown that the employee was impaired at the time of the injury, there shall be a rebuttable presumption that the accident, injury, disability or death was contributed to by such impairment.

An employee's refusal to submit to a chemical test at the request of the employer shall result in the forfeiture of benefits under the Workers Compensation Act if the employer had sufficient cause to suspect the use of alcohol or drugs by the claimant, or if the employer's policy clearly authorizes post-injury testing.

The results of a chemical test shall be admissible evidence to prove impairment if the employer establishes that the testing was done under any of the following circumstances:

1. as a result of an employer-mandated drug testing policy, in place in writing prior to the date of accident or injury, requiring any worker to submit to testing for drugs or alcohol;
2. during an autopsy or in the normal course of medical treatment for reasons related to the health and welfare of the injured worker and not at the direction of the employer;
3. the worker, prior to the date and time of the accident or injury, gave written consent to the employer that the worker would voluntarily submit to a chemical test for drugs or alcohol following any accident or injury;
4. the worker voluntarily agrees to submit to a chemical test for drugs or alcohol following any accident or injury; or
5. as a result of federal or state law, or a federal or state rule or regulation having the force and effect of law, requiring a post-injury testing program and such required program was properly implemented at the time of testing.

*An employee is considered to be impaired from alcohol if the blood alcohol concentration at the time of injury is .04 or more.

** Confirmatory test cutoff levels (ng/ml)

Marijuana metabolite	15	Opiates:	
Cocaine metabolite	150	Morphine	2000
Amphetamines:		Codeine	2000
Amphetamine	500	6-Acetylmorphine	10ng/ml
Methamphetamine	500	Phencyclidine	25

Safety Violations: K.S.A. 44-501(a)(1)

Compensation for an injury shall be disallowed if such injury to the employee results from:

1. the employee's deliberate intention to cause such injury;
2. the employee's willful failure to use a guard or protection against accident or injury which is required pursuant to any statutes and provided for the employee;
3. the employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer;
4. the employee's reckless violation of their employer's workplace safety rules or regulations; or
5. the employee's voluntary participation in fighting or horseplay with a co-worker for any reason, work related or otherwise.

The preceding shall not apply when it was reasonable under the totality of the circumstances to not use such equipment, or if the employer approved the work engaged in at the time of an accident or injury to be performed without such equipment.

Coronary Disease and Stroke

The law does not provide compensation for coronary or coronary artery disease or cerebrovascular injury (e.g., stroke), unless it is shown that the exertion of the work that caused the injury was beyond that required by the employee's usual job duties. Another exception is vascular injury caused by extreme heat.

Prior Disability Ratings/Pre-existing Condition

Compensation for any permanent disability may be reduced by the existence of a rating on any applicable pre-existing disability.

K.S.A.44-501(e): An award of compensation for permanent partial impairment, work disability or permanent total disability shall be reduced by the amount of functional impairment determined to be pre-existing. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

K.S.A.44-501(e)(1): Where workers compensation benefits have previously been awarded through settlement or judicial administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be pre-existing. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of pre-existing functional impairment shall be established by competent evidence.

Guidelines for Obtaining Medical Treatment

Who Pays?

Employers are responsible for all medical treatment necessitated by a job-related injury or disease. This includes:

- services of a licensed health care provider;
- surgical, hospital and other medical treatment;
- medications, medical and surgical supplies;
- nursing services;
- crutches and other medical apparatus;
- ambulance services; and
- transportation between the employee's home and the place of medical treatment, subject to a minimum of five miles round trip.

If an employer has workers compensation insurance, the insurance carrier is required to pay for applicable medical expenses. Uninsured employers subject to workers compensation laws are still responsible for the medical bills of covered employees.

Employers are legally entitled to choose the treating physician. If an employee self-selects a physician who is not authorized or agreed upon by the employer, the employer is responsible for only the first $500 in medical bills from such self-selected physicians.

Employer-Ordered Examinations

After obtaining whatever emergency medical care is necessary, an employee shall submit to any reasonable physical examination ordered by the employer. The employer can also require the employee to submit to ongoing examinations – up to twice monthly, or more often if specifically ordered by the Division of

Workers Compensation. Employees may forfeit the benefits that are available if they refuse to submit to such examinations. Employees are entitled to know the results of any physical examination ordered by the employer. At the employee's request, the doctor conducting the examination must furnish the employee, within a reasonable time after the examination, a report identical to that sent to the employer or the employer's carrier. Employees are entitled to have their own doctor present at, and participate in, any medical examination ordered by the employer. If this is not allowed, or if employees are not furnished a copy of the medical report, then the examination ordered by the employer will not be allowed as evidence related to the claim.

Fraud and Abuse

Both the Division of Workers Compensation and the Kansas Insurance Department have units dedicated to the investigation of fraudulent or abusive acts and practices that occur with regard to the Workers Compensation Act. Acts or conduct that are considered to be fraudulent or abusive can generally be described as situations in which claimants, employers or companies fail or refuse to follow directives of the Workers Compensation Act. The Workers Compensation Act applies to the following:

- persons claiming benefits under the Workers Compensation Act;
- employers subject to the requirements of the Workers Compensation Act;
- insurance carriers and group-funded self-insurance plans providing coverage for work-related injuries;
- any person, corporation, business or health care facility providing treatment for work-related injuries
- attorneys and other representatives of employers, employees, insurers or other entities involved in the administration of the Workers Compensation Act.

If the director, or the assistant attorney general assigned to the Division of Workers Compensation, has probable cause to believe a fraudulent or abusive act or practice that violates the Workers Compensation Act has occurred, a copy of any order and all investigative reports and any evidence in the possession of the Division of Workers Compensation which relates to such act shall be forwarded to the prosecuting attorney of the county in which the act occurred.

Any person who believes a violation of the Workers Compensation Act has occurred may notify the Division of Workers Compensation immediately and should send the information relating to the alleged violation to the division. The director shall evaluate the facts surrounding the alleged violation to determine the extent, if any, to which violations of the Workers Compensation Act exist. For more information, call (785) 296-4000 or (800) 332-0353; or send email to KDOL.WCFraud@ks.gov .

Any person who has a complaint against an insurance company, or other person/entity regulated by the Kansas Insurance Department, regarding the handling of a workers compensation claim, should contact the Anti-Fraud Division at the Kansas Insurance Department. Complaints may be made by calling (800) 432-2484 or (785) 296-3071, in writing by sending information to the Anti-Fraud Division at 1300 SW Arrowhead Rd., Topeka, KS 66604 or online at www.insurance.kansas.gov.

Coverage and Compliance

The Compliance section monitors and assists employers to ensure that they fulfill two requirements under the Workers Compensation Act:

1. to secure workers compensation benefits for employees and
2. to file written reports of alleged work accidents.

Failure to secure workers compensation benefits or report accidents can result in monetary penalties against the employer. Failure to secure workers compensation benefits can also result in closure of the business.

Per K.S.A. 44-557, "it is...the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained."

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at https://www.dol.ks.gov/WC/insurer.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014 is outlined in KA.R. 51-9-17.

When the director has reason to believe an employer has engaged in the knowing and intentional failure to secure the payment of workers compensation to its employees, the director shall issue and serve upon such employer a statement of the charges and shall conduct a hearing in accordance with the Kansas Administrative Procedure Act. The employer may be liable to the state for a civil penalty in an amount equal to twice the annual premium or $25,000, whichever amount is greater.

The director shall order employers to come under the Workers Compensation Act by:

1. insuring and keeping insured the payment of such compensation with an insurance carrier authorized to transact the business of workers compensation insurance in the state of Kansas;

2. showing to the director that the employer carries such employer's own risk and is what is known as a self-insurer and by furnishing proof to the director of the employer's financial ability to pay such compensation for the employer's self; or

3. maintaining a membership in a qualified group-funded workers compensation pool. The cost of carrying such insurance or risk shall be paid by the employer and not the employee.

For more information, call (785) 296-4000 or (800) 332-0353; or send email to KDOL.WCCompliance@ks.gov or go to www.dol.ks.gov.

Verify Coverage

You can check whether a business has workers compensation coverage online. The website provides public access to portions of the information reported by private workers compensation insurance carriers for use by the Kansas Department of Labor (KDOL). The accuracy of data from any third party cannot be guaranteed by the agency and KDOL is not responsible for the coverage information available through this link.

For additional help with verifying workers compensation coverage in Kansas, call Workers Compensation Coverage and Compliance at (785) 296-4000.

Safety and Health Services

Workplace safety and accident prevention is a key element of the law. This requirement was designed to reduce claims/losses which would hold down premiums for employers. Because rates are based on losses, the prevention of employee accidents through enhanced safety measures is one of the best ways employers can help keep rates down.

By law, insurance carriers and group-funded plans must provide accident prevention programs upon request to their insureds. Notice of such accident prevention programs must appear on the front page of every policy issued after July 1993.

Programs Offered by the Kansas Department of Labor

Consultation: offers assistance to private sector employers in safety and health program evaluations. Consultants offer advice in the recognition, evaluation and control of hazards in the workplace. Assistance with program initiation and development is available. Training, both formal and informal, is performed in all areas of safety and health. All services are at no cost to the client.

Public Sector Compliance: monitors the public sector – cities, counties, state agencies and school districts – by performing compliance audits under K.S.A. 44-636 and/or K.S.A. 44-575(f). Occupational hazards are identified and program elements are assessed. Hazards must be abated within 60 days. Investigations of employee complaints, near misses and fatalities are also conducted.

Accident Prevention: evaluates insurance companies and group-funded self-insurance plans to ensure that they are offering and providing safety and health services at no charge to their insureds as required by law. The quality and quantity of these services are evaluated by trained consultants by directly reviewing insurance company records and contacting those insured who have requested and been provided services. Accident prevention assistance is available by emailing KDOL.WC@ks.gov. You can also find information online at www.dol.ks.gov/Safety/accident.aspx.

Safety and Health Conference: the annual Kansas Safety and Health Conference brings industrial, academic, vendor and government safety representatives together. The conference is self-supporting and seeks to address the relevant safety issues in a variety of workshops and presentations.

Workplace safety and health assistance is available by calling (785) 296-4386 or by emailing KDOL.IndSafetyHealth@ks.gov. You can also find information online under Workplace Safety at www.dol.ks.gov.

Ombudsman Services

The Kansas Division of Workers Compensation established a Claimant Advisory Section in 1978. In 1993 the Legislature followed a national trend and, by statute, created the ombudsman program. The workers compensation reform legislation of 1993 mandated an expanded role for the Claims Advisory Section to enable a more proactive approach to assisting all parties in understanding their rights and responsibilities under the Workers Compensation Act.

The division employs full-time personnel who specialize in aiding injured workers, employers and insurance professionals with claims information and problems arising from job-related injuries and illnesses. The ombudsman acts in an impartial manner and is available to provide the parties with information about the current issues within the workers compensation system. For example, the ombudsman has current information on legislative changes or changes due to decisions made by the Workers Compensation Board or the courts. The ombudsman section also can assist with specific issues on current workers compensation claims.

Assisting Injured Workers with:

- Providing general information
- Obtaining medical treatment
- Benefits not being paid or not being paid on a timely basis
- Unpaid medical benefits
- Calculations of benefits
- Timely notification of employer
- Procedures for filing for a hearing
- Obtaining survivors' benefits
- Informal dispute resolution
- Mediation assistance
- Interpretation for Spanish-speaking workers

Assisting Employers/Insurance Companies with:

- Providing general information
- Posting Workers Compensation Notice (K-WC 40-A)
- Providing required information to injured workers (K-WC 27-A or K-WC 270-A)
- Timely submission of accident reports
- Timely and appropriate payment of medical services
- Election information
- Assistance with death benefit requirements
- Informal dispute resolution
- Assistance with Spanish-speaking workers
- Employer staff training on workers compensation issues

Ombudsman assistance is available either in person or by calling (785) 296-4000 or (800) 332-0353. You also may send an email to KDOL.WC@ks.gov. Additionally, forms are available for download at www.dol.ks.gov.

Employer Services Unit

For technical assistance, and presentations and training for employers, call (785) 296-4000 or (800) 332-0353, or email KDOL.WCEmployerServices@ks.gov.

Mediation

Mediation was legislatively created in 1996 (K.S.A. 44-5,117) and can be utilized at any point during the workers compensation process. The statute was amended in 1998 to allow mediation by video conferencing. Mediation is not mandatory or a prerequisite to a hearing and it may be utilized at any time during the worker compensation process. The issues that can be mediated are not restricted to medical or temporary total disability benefits.

What Is Mediation?

Mediation is a means of resolving disputes in an informal and non-adversarial atmosphere. The parties to a dispute use a neutral third party to facilitate the discussion. The mediator has no decision making authority or interest in the outcome to the dispute. The mediator's job is to assist the parties in identifying the issues in dispute and establishing common goals. The key to mediation is allowing the parties to work through their dispute and create their own agreements (self-determination).

Who Are the Mediators?

The mediators are employees of the Division of Workers Compensation who have received special training in the process of mediation. The mediators used by the Division of Workers Compensation meet or exceed the requirements established by K.S.A. 5-501 and amendments thereto, and any relevant rules of the Kansas Supreme Court as authorized pursuant to K.S.A. 5-510, and amendments thereto. Mediators receive training in conflict resolution techniques, neutrality, agreement writing, ethics, role playing, communication skills, evaluation of cases and the laws governing mediation.

Representation and Assistance

Any party may be represented by an attorney at this mediation conference or may request assistance from the Ombudsman/Claims Advisory section. The absence of an attorney during the process does not mean legal representation cannot be obtained later if the dispute is not settled in this informal setting.

For additional information or to schedule a mediation conference, please call (785) 296-4000 or (800) 332- 0353. Write to Mediation Section, Kansas Department of Labor, Division of Workers Compensation, 401 SW Topeka Blvd., Topeka, KS 66603-3105. You may send email to KDOL.WC@ks.gov.

Medical Services

The primary function of the Medical Services section is the administration of the Schedule of Medical Fees. The fee schedule is updated and revised on an annual basis to promote health care cost containment, yet insure the availability of necessary treatment and care for injured employees.

The Medical Services section is available to act as a liaison between health care providers, employers, employees, insurance carriers, group-funded pools or self-insured businesses. Additionally, the section conducts informal hearings to assist in the resolution of disputed medical claims and related payments involving health care providers.

For assistance in resolving issues related to fee schedule interpretation, payment disputes, etc., contact the Medical Services section at (785) 296-4000 or fax (785) 296-0025.

Vocational Rehabilitation

Vocational rehabilitation may be provided at the option of the employer or the employer's insurance carrier. General experience has shown that the longer the length of time away from work recovering from an injury, the greater the likelihood that an employee will need vocational rehabilitation to resume suitable work at comparable pay.

If the employer or insurance carrier does not choose to provide for vocational rehabilitation, the employee can ask the rehabilitation administrator for a referral to a provider of such services, at the employee's expense. The employee can also request a referral to the Division of Rehabilitation Services in the Kansas Department for Children and Families.

For assistance with vocational rehabilitation, contact the rehabilitation administrator's office in the Division of Workers Compensation at (800) 332-0353 or (785) 296-4000 or send email to KDOL.WCRehab@ks.gov.

Kansas Department of Labor
Division of Workers Compensation

Kansas Department of Insurance

Información de Compensación De Trabajadores para Empleadores y Empleados del Estado de Kansas

Copias de las formas de elección, reportes de accidente, exhibición de aviso (K-WC 40-A) y todos los demás carteles obligatorios están disponibles para descargarse en www.dol.ks.gov/WorkComp/frmpub2.aspx.

Para obtener información adicional sobre los beneficios de compensación de trabajadores, directrices para empleadores y otra información general, contacte:

Departamento de Laboral de Kansas
División de Compensación de Trabajadores
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603
(785) 296-4000
(800) 332-0353
Correo electrónico: **wc@dol.ks.gov**
Sitio en internet: **www.dol.ks.gov**

Síganos:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

Para más información en tarifas de seguro para compensación de trabajadores y conducta de compañías aseguradoras, contacte:

Departamento de Seguros de Kansas
420 S.W. 9th St. Topeka,
Kansas 66612-1678 (785)
296-3071
(800) 432-2484

Correo electrónico: **commissioner@ksinsurance.org**
Sitio en internet: **www.ksinsurance.org**

Índice

¿Qué es Compensación de Trabajadores?

Compensación de trabajadores es un plan de seguro requerido del empleador para pagar beneficios al empleado por lesiones relacionadas con el trabajo, incapacidad o muerte que surgen de y en el curso del empleo.

De acuerdo al artículo de ley K.S.A. 44-508, se considerará que una lesión por accidente surge del empleo si:

- Hay una conexión casual entre las condiciones bajo las cuales el trabajo es requerido a ser realizado y el accidente resultante; y
- El accidente es el factor predominante causando la lesión, condición médica y la resultante discapacidad o impedimento físico.

Las palabras "surgen de y en el curso del empleo" como se usan en la ley de compensación de trabajadores no se interpretarán para incluir:

- Lesión que se produjo como resultado del proceso de envejecimiento natural o por las actividades normales del vivir diario;
- Accidente o lesión que surgió de un riesgo neutral sin empleo particular o de carácter personal;
- Accidente o lesión que surgió de un riesgo personal para el trabajador; o
- Accidente o lesión que surgió directa o indirectamente por causas desconocidas.

Los beneficios son pagados a expensas del empleador. La cobertura empieza el primer día de trabajo.

La presente ley abarca todos los empleadores de Kansas excepto aquellos en ciertas actividades agrícolas o aquellos con una nómina anual bruta de 20,000 dólares o menos. Toda nómina es tomada en cuenta, incluyendo la que es pagada en Kansas o en otras partes. Si el empleador es un único propietario o una miembro de una asociación, los salarios pagados a los propietarios y a cualquiera de sus familiares no se utilizan en el cálculo de la nómina anual bruta. De acuerdo con K.A.R 51-11-6, la disposición en K.S.A. 44-505 excluyendo la nómina de trabajadores que son miembros de la familia del empresario no se aplicará a las corporaciones. La nómina de una corporación para el propósito de determinar si el empleador es sujeto a la ley de compensación del trabajadores o no, deberá ser determinada por la suma total de los sueldos pagados a los empleados corporativos incluso cuando un empleado de la corporación ha elegido no ser cubierto por la ley de compensación de los trabajadores en conformidad con K.S.A. 44-543.

Los empleados discapacitados debido a una enfermedad o lesión relacionada con el trabajo tienen derecho a:

- gastos médicos para tratar la lesión relacionada con el trabajo o la enfermedad; y
- beneficios de ingresos para sustituir parte del salario perdido debido a la discapacidad.

Si muerte resulta de una enfermedad o lesión relacionada con el trabajo, podrán pagarse beneficios al cónyuge sobreviviente, dependientes o herederos.

Propósito de la Ley

Kansas pasó su primera ley de compensación trabajadores en el año de 1911. Mediante la regulación de los litigios y los beneficios, la ley está diseñada para proteger los intereses de los empleadores y empleados. Los empleadores se benefician mediante sustituir un gasto conocido (primas) por el riesgo a largo plazo de gastos no presupuestados, en caso de discapacidad grave del empleado. Los empleados se benefician debido a que la negligencia del empleador no es una cuestión en la determinación de responsabilidad. Cobertura de compensación de trabajadores es un sistema sin culpa. Las disposiciones de la Ley de Compensación de Trabajadores se aplicarán imparcialmente a los empleadores y empleados. Aunque inicialmente la ley estaba destinada a trabajos peligrosos, ahora cubre a la mayoría de los trabajadores.

Elecciones

Elecciones dentro o fuera de la Ley de Compensación de Trabajadores son opciones disponibles para los empleadores o empleados. Dependiendo de las circunstancias, las opciones pueden estar disponibles para:

- empleadores no cubiertos: por ejemplo, aquellos con nóminas de 20,000 dólares o menos o en ciertas actividades agrícolas;
- empleados de una corporación dueños de 10 por ciento o más de las acciones;
- individuos, propietarios o asociaciones ;

- empleadores buscando cobertura para voluntarios y otros trabajadores no cubiertos; y
- directores voluntarios, funcionarios o administradores de una organización sin fines de lucro.

Ejemplo: Una asociación de dos personas tiene dos empleados: un miembro de la familia y uno que no es miembro de la familia: y una nómina anual de 15,000 dólares. La asociación puede optar por adquirir la cobertura bajo la ley y extender dicha cobertura a ambos empleados. Los socios no están cubiertos porque son considerados como el empleador.

Formas de elección pueden encontrarse en el Internet en **www.dol.ks.gov** .

Derechos y Responsabilidades de los Empleados

La Ley del estado de Kansas protege el derecho del empleado y facilita la obtención de compensación del trabajador Específicamente:

- Un empleado no puede ser despedido, degradado o discriminado de cualquier otra manera por la presentación de un reclamo en buena fe.
- Los empleados deben ser informados de sus derechos y responsabilidades en caso de lesion. En el caso de muerte del empleado, dicha información deberá aportarse a los beneficiarios del empleado.
- No se debe imponer un pago a los empleados para reclamos de compensación de trabajadores. Los empleadores no puede deducir del sueldo o de los beneficios para pagar las primas de seguros o reclamos.
- Empleados pueden tener derecho a beneficios de compensación de un empleador sujeto a la Ley independientemente de la cobertura del seguro.
- Empleados pueden obtener asistencia gratuita mediante ponerse en contacto con la oficina Ombudsman de Compensación de Trabajadores a los teléfonos (800) 332-0353 o (785) 296-4000.
- La ley estipula sanciones específicas por fraude tanto a empleados como empleadores en casos de compensación de trabajadores. Para más información o asistencia, o para reportar sospecha de fraude, póngase en contacto con la Oficina Ombudsman de Compensación de Trabajadores o la. Oficina de Fraude y Abuso a los teléfonos (785) 296-4000 o (800) 332-0353.

Responsabilidades del Empleador

Seguro de Compensación para Trabajadores

La mayoría de los empleadores están obligados por ley a proveer el pago de reclamos de compensación de trabajadores, sin ningún costo para el empleado. Los empleadores deberán cumplir con este requisito de tres maneras:

- Seguro de compensación de trabajadores: obtenida de una compañía de seguros con licencia; el empleador paga las primas y la compañía de seguros paga los reclamos. Las compañías de seguros son reguladas por el Departamento de Seguros del estado de Kansas.
- Auto-seguro: un empresario individual debe demostrar al Estado de Kansas la capacidad financiera para pagar cualquier reclamo que pudiera surgir. Este programa es administrado por la División de Compensación de Trabajadores.
- Grupo financiero de fondo común: un grupo de empresarios que cumplen ciertos requisitos legales pueden formar un programa de auto-seguro para asegurar conjuntamente su capacidad para pagar los reclamos Este programa es administrado por el Departamento de Seguros del estado de Kansas.
- Falta deliberada de proveer el pago de compensación de trabajadores en una de las formas anteriores es un delito menor, clase A y somete al empleador a una pena civil en una cantidad dos veces la prima anual que el empleador hubiera pagado por seguro o 25,000 dólares, cualquiera de las cantidades que sea mayor.

Categorías de empleo excluidos de la ley son:

- ciertas actividades agrícolas;
- agentes inmobiliarios que califican como contratistas independientes;

- empleadores con nóminas anuales brutas de 20,000 dólares o menos;
- bomberos pertenecientes a una asociación de socorro de bomberos que ha renunciado la cobertura bajo la Ley de Compensación de los Trabajadores; y
- ciertos conductores de vehículos que son propietarios y que están cubiertos por su propia póliza de seguro de accidente laboral.

Otros Requisitos

- Los empleadores deben exponer el aviso escrito (K-WC 40-A), comunicando a los empleados qué hacer en caso de un accidente.
- *De acuerdo con la ley K.S.A. 44-557, es...la responsabilidad de cada empleador de hacer o causar que se haga un reporte a el director* de cualquier accidente, reclamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones*.
- Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en: http://www.dol.ks.gov/WorkComp/edinews.aspx.
- **Inmediatamente al enterarse de la lesión o la muerte de un empleado, el empleador deberá suministrar información por escrito al empleado o a los dependientes del empleado sobre los beneficios disponibles, el proceso de reclamo, el empleador o compañía de seguros de contacto para reclamos de compensación de trabajadores y otros asuntos como es requerido por la ley**. Las formas K-WC 27-A y K-WC 270-A (en español) está disponibles en internet, en el sito de la División de Compensación de Trabajadores en: www.dol.ks.gov/WorkComp/frmpub2.aspx.
- Un empleador con seguro o auto-asegurado deberá suministrar el siguiente aviso a un *trabajador asegurado o con el primer cheque de beneficios de incapacidad temporal: Advertencia: aceptación de empleo con un empleador diferente que requiere la realización de actividades que usted ha declarado que no puede realizar debido a la lesión por la que está recibiendo beneficios de incapacidad temporal puede constituir fraude y podría resultar en pérdida de beneficios en el futuro y la restitución de previas indemnizaciones y beneficios pagados.*

Si necesita ayuda, llame a (800) 332-0353 o (785) 296-4000.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A.R. 51-9-17.

Categorías de Beneficios por Incapacidad

Incapacidad Total Temporal

Existe cuando el empleado, a causa de una lastimadura, no ha podido participar en cualquier tipo de empleo sustancial y remunerativo. Beneficios son pagados por la duración de la incapacidad temporal total (TTD por sus siglas en inglés). Existe un período de espera de una semana (siete días consecutivos) antes de que los beneficios temporales (TTD) sean pagados. Si la discapacidad continua por tres semanas consecutivas, el empleado es reembolsado por el período de espera. Empleados pueden obtener beneficios médicos durante la primera semana. Los beneficios temporales son 66.67 por ciento del promedio del sueldo semanal bruto del

empleado, pero no menos de 25 dólares ni más que el máximo legal vigente. La compensación total no debe exceder de 130,000 dólares por lesion.

Los empleados no podrán cobrar beneficios de incapacidad total temporal y beneficios de desempleo por las mismas semanas.

Incapacidad Parcial Temporal

Existe cuando el trabajador regresa a cualquier clase de empleo ganando un sueldo inferior a aquel que tenía al tiempo de lesionarse. La compensación es calculada sobre una base semanal y se paga hasta que no hay más pérdida del sueldo o hasta que el máximo beneficio es alcanzado, lo que ocurra primero.

Los beneficios son 66.67 por ciento de la diferencia entre el salario promedio bruto semanal del empleado antes de la lesión y el salario del empleado después de la lesión pero no pueden exceder el máximo legal vigente en el estado.

Incapacidad Parcial Permanente

Existe cuando hay pérdida total o parcial del uso de una parte del cuerpo, como un brazo, debido a una lesión relacionada con el trabajo. Compensación para una incapacidad parcial permanente se limita a un porcentaje de la tabla siguiente. Un período de curación está disponible en los casos de amputación. Los beneficios son 66.67 por ciento de un salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal de 130,000 dólares.

Lista de información de beneficios

Pérdida o pérdida del uso de:	semanas pagadas:	Pérdida o pérdida del uso de:	semanas pagadas:
Hombro	225	Dedo Pulgar	60
Brazo	210	Dedo índice	37
Antebrazo	200	Dedo medio	30
Mano	150	Dedo anular	20
Pierna	200	Dedo meñique	15
Pierna inferior	190	Dedo gordo del pie	30
Pie	125	Dedo gordo del pie (articulación de la punta)	15
Ojo	120	Cada dedo del pie	10
Oído (ambos)	110	Cada dedo del pie (articulación de la punta)	5
Oído (uno solo)	30		

Incapacidad General Parcial Permanente

Existe cuando un empleado se ha incapacitado de tal manera que es de character parcial y de calidad permanente y que no está cubierto por lo enlistado anterior. Por ejemplo, discapacidad envolviendo la espalda o la pérdida del uso de un hombro, brazo, antebrazo o mano, de una extremidad superior, combinada con la pérdida o pérdida uso de un hombro, brazo, antebrazo o mano, de la otra extremidad superior; o la pérdida o pérdida de uso de una pierna, pierna baja o pie, de una extremidad inferior, combinado con la pérdida de o pérdida del uso de una pierna, pierna baja o pie, de la otra extremidad inferior; o la pérdida de o pérdida del uso de ambos ojos que es parcial en carácter y permanente en calidad son discapacidades de todo el cuerpo y no están cubiertos por la lista anterior. Compensación por tales discapacidades "no programadas" o "cuerpo entero" se basa en el mayor de lo siguiente: el porcentaje de impedimento funcional; o la capacidad reducida del empleado para realizar tareas de.trabajo y el sueldo semanal promedio que empleado es capaz de ganar después de la lesion. Empleados ganando 90 por ciento del sueldo que tenían antes de la lesión están limitados a impedimento funcional.

Calculando beneficios de incapacidad general parcial permanente

1. Cálculo el porcentaje de beneficio semanal mediante la identificación de la menor de estas dos cantidades: Sueldo promedio semanal bruto x 66.67 por ciento; o el máximo legal vigente.
2. Cálculo de las semanas de compensación permitidas: se empieza con 415 semanas. De las 415, se restan las semanas en que se pagó incapacidad total temporal, excluyendo las primeras 15 semanas de TTD. Se multiplica la diferencia por el porcentaje de incapacidad.
3. Cálculo del total de los beneficios: Se multiplican los beneficios semanales por el número de semanas de compensación permitidas.

Ejemplo: El sueldo promedio semanal es 875 dólares en la fecha del accidente (10/07/2011). El empleado ha cobrado 25 semanas de incapacidad total temporal (TTD) y tiene una un porcentaje de incapacidad del 25 por ciento.

Beneficio semanal: (utilice la cantidad menor)

$875 x .6667 = $583.36

Máximo legal (a partir del 07/01/11) $555

Semanas de compensación permitidas:

415 - [25-15] = 415 - 10 = 405 semanas

405 semanas x .25 = 101.25 semanas

Cantidad de beneficio máximo:

101.25 semanas x $555 = $56,193.75

Nuestro sitio en Internet tiene un programa de cálculo de beneficios de compensación de trabajadores. El programa de fechas le permite calcular el tiempo entre dos fechas o para calcular la suma de días a una fecha conocida. Los programas de la lista de lesiones y lesiones del cuerpo entero le permitirán calcular los beneficios de compensación a la que tiene derecho el reclamante. Se proporcionan instrucciones paso a paso para cada programa.

Incapacidad Total Permanente

Existe cuando el empleado, a causa de la lesión, ha quedado completa y permanentemente incapaz de participar en cualquier tipo de empleo remunerado y sustancial. Pérdida de ambos ojos, ambas manos, ambos brazos, ambos pies, ambas piernas o cualquier combinación de éstas, en ausencia de prueba de lo contrario, deberán constituir una incapacidad permanente total. Parálisis total considerable o imbecilidad incurable o locura, resultantes de lesiones independientes de todas las otras causas, también constituirán incapacidad total permanente.

Los beneficios son 66.67 por ciento del salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal. La compensación total no debe exceder 155,000 dólares por lesion.

Un empleado no puede recibir más de una indemnización de incapacidad total permanente en la vida.

Cómo se Determinan las Tasas de interés

El seguro de compensación de trabajadores en Kansas es obligatorio por la ley estatal para la mayoría, pero no para todos los empleadores.

Las primas pagadas por los empleadores deberían ser suficientes para cubrir los reclamos incurridos por sus compañías de seguros. Las tasas de interés se ajustan en función de las primas más recientes, los ingresos de inversión y pérdidas reportadas por las compañías de seguros. El Consejo Nacional de Seguros Compensatorios (NCCI por sus siglas en inglés) presenta estas tasas de interés anualmente al Comisionado de Seguros para su aprobación.

El Consejo Nacional de Seguros Compensatorios (NCCI) es una organización clasificadora, autorizada por el departamento de seguros, cuya composición, primordialmente consta de compañías de seguros. Ellos desarrollan el cambio necesario de la tasa de interés anual basándose en las pérdidas y primas reportadas a ellos por las compañías de seguros miembros de dicha organización.

El Departamento de Seguros de Kansas regula las tarifas que se cobran en el estado. Cada año, éste Departamento revisa las primas, los costos de los reclamos y otros datos pertinentes presentados por el NCCI para determinar si se recomienda un cambio en la tasa de interés o no Actualmente, alrededor de 70 centavos de cada dólare recogidos en el cobro de las primas, se proyecta para cubrir el costo de pagar reclamos de compensación de trabajadores. Aproximadamente 27.5 por ciento de cada dólar es utilizado por las compañías de seguros para cubrir otros costos de hacer negocios: por ejemplo, gastos administrativos, salarios y gastos generales. El margen de beneficio se proyecta en aproximadamente un 2.5 por ciento Además de las ganancias de las inversions.

Después de revisar la presentación de la tasa de interés, el Comisionado de seguros generalmente aprueba un cambio "global" en la prima estatal. Este cambio "global" se expresa como un porcentaje (por ejemplo, un cinco por ciento de aumento global); Sin embargo, los tipos básicos de clasificación individual pueden aumentar o

disminuir más del cambio "global". Los tipos básicos de clasificación individual deben continuar reflejando la experiencia (las primas y pérdidas) de los empleadores en cada clasificación.

Componentes de la Prima

Las primas de seguro de compensación de trabajadores se calculan basándose en varios factores. Los principales son:

Tasa de interés básica: el punto de partida para el cálculo de las primas. La tasa de interés o costo de pérdida es presentado por NCCI y todas las aseguradoras requeridas de usarla. Esta podría cambiar anualmente basada en la experiencia de la pérdida de otros empleadores en todo el estado en la misma clasificación. Las compañías multiplican la tasa de interés por su Multiplicador de Costo de pérdida aprobado para determinar la tasa de interés por cada 100 dólares de nómina.

Clasificación: un factor clave para determinar la tasa de interés que un empleador pagará. La clasificación denota la tipo de negocios; trabajos peligrosos tienen más probabilidades de provocar reclamos importantes y costosos y, por tanto, tienen una tasa de interés más alta. Hay unas 600 clasificaciones en uso en Kansas.

Clasificación basada en la experiencia: aefcta la prima basada en la frecuencia y gravedad de los reclamos de compensación de los empleadores con tamaño de prima suficiente para ser "clasificados por experiencia". Actualmente, los empleadores con una prima anual de por lo menos 4,500 dólares en los últimos dos años, o si más de dos años, una prima promedio anual de 2,250 dólares o más son calificados de experiencia Más pocos y menos costosos reclamos significan un factor modificación por experiencia más bajo, lo que significa una prima menos costosa.

Tamaño de la nómina: los empleadores con grandes nóminas generan primas anuales de compensación de trabajadores mayores que aquellos con una nómina más pequeña en la misma clasificación. Sin embargo, los gastos de distribución y abastecimiento de la póliza no incrementa en proporción directa a la prima de la póliza. En consecuencia, un descuento en la prima puede aplicarse a las pólizas con una prima más grande para reconocer este factor.

También, algunos empleadores están sujetos a cantidades de nómina fija Socios, propietarios y miembros de una compañía de responsabilidad limitada que eligen cubrirse bajo una póliza de seguro de compensación de trabajadores pagan una prima basada en una nómina fija la cual se ajusta anualmente. La prima para un funcionario ejecutivo de una empresa se basa en la nómina actual del oficial, sujeta a una nómina mínima y un máxima establecida por semana, la cual que puede ser ajustada anualmente.

Factores que Afectan a las Primas

Tres de los factores más importantes en la reducción de las primas son:

1. **Implementación de un programa de prevención de accidentes:** estos programas fueron ordenados por la legislatura de 1993 y están disponibles a los empleadores por todas las compañías de seguros y grupo financiado por un fondo común operando en Kansas. Porque los programas de prevención de accidentes han demostrado reducir la frecuencia y la gravedad de las lesiones, que ofrecen a los empleadores la posibilidad de reducir las primas. La reducción de la prima es, por supuesto, sólo uno de los beneficios de la prevención de accidentes que los empleadores deben tener en cuenta.
2. **Asegurándose que la(s) clasificación(es) adecuada(s) ha(n) sido usada(s) para calcular la prima:** la clasificación utilizada en la póliza debe describir, tan razonable y preciso como sea posible, el negocio del empleador y los deberes del empleado. El uso de una clasificación inadecuada puede resultar en pago de una prima incorrecta. Si la clasificación no parece describir con precisión un trabajo en particular, ayuda para verificar que se utilizó la clasificación adecuada o para obtener una corrección, está disponible llamando al Departamento de Seguros al teléfono: (800) 432-2484 o (785) 296-3071 o visitando el sitio en internet www.ksinsurance.org.
3. **Uso de deducible:** los deducibles pueden ser una manera efectiva de reducir las primas y están disponibles en diversas cantidades. No se aplicarán las pérdidas pagadas por el empleador bajo el deducible para calcular la modificación de la experiencia del empleador. El asegurador deberá pagar el importe de deducible y solicitar el reembolso del empleador asegurado por la cantidad del deducible applicable.

Información General

Cómo Obtener un Seguro

Cobertura de seguro de compensación de trabajadores puede obtenerse por:

- ponerse en contacto con un agente de seguros con licencia;
- ponerse en contacto con el departamento de seguros de Kansas para obtener información sobre grupos financiados por el grupo; o
- ponerse en contacto con la División de compensación de trabajadores para obtener información sobre auto-seguro.

Plan de Seguro de Compensación para Trabajadores de Kansas (Plan de Riesgo Asignado)

Cualquier empresario que tenga derecho pero que no pueda adquirir cobertura en el mercado de seguros de indemnización de trabajadores voluntario, puede obtener cobertura en el Plan de riesgo Asignado Esto significa que un empleador es asignado a una compañía de seguros que está autorizada para proporcionar cobertura. Las primas para el Plan de Riesgo Asignado se calculan utilizando los mismos costos de pérdida como si la cobertura hubiese sido comprada en el mercado voluntario; sin embargo, las primas pueden ser mayores debido a recargos adicionales que se basan en la tamaño del empleador de prima y pérdida de experiencia.

Para asistencia y preguntas relacionadas al Plan de Riesgo Asignado llame al Departamento de Seguros del estado de Kansas a los teléfonos (800) 432-2484 o (785) 296-3071.

Proceso de Apelación de Clasificación de Seguro

Si un empleador sospecha de una clasificación errónea u que otro factor incorrecto has sido utilizado para calcular una prima, la clasificación puede ser apelada por escrito a la compañía de seguros de la que se obtuvo la cobertura. El empleador también puede apelar por escrito al Comisionado de Seguros del estado de Kansas resumiendo la naturaleza de la queja o apelación.

Para información adicional o asistencia para apelar o corregir un error de clasificación u otro problema de clasificación, comuníquese con el Departamento de Seguros de Kansas al (800) 432-2484 o (785) 296-3071.

División de Responsabilidades

Responsabilidades del Empleado:

Notificar al empleador inmediatamente. De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Mayo 15, 2011, y antes de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 30 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 20 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 20 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma repetitivo;
- 20 días consecutivos a partir de la fecha que recibió tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 10 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

El aviso podrá darse verbalmente o por escrito. Donde el aviso se proporciona oralmente, si el empleador tiene designado a un individuo o departamento a quien debe darse el aviso y tal designación ha se ha comunicada por escrito al empleado, aviso a cualquier otra persona o departamento será insuficiente en esta sección. Si el empleador no ha designado a un individuo o departamento a quien debe darse aviso, el aviso debe proporcionarse a un administrador o supervisor.

Donde el aviso es provisto por escrito, aviso debe enviarse a un supervisor o gerente en la ubicación principal de trabajo del empleado.

El aviso, ya sea que se suministre oralmente o por escrito, deberá incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesion. Debe ser evidente a partir del contenido del aviso de que el empleado está cobrando beneficios bajo la Ley de Compensación de Trabajadores o ha sufrido una lesión relacionada con el trabajo.

Responsabilidades del Empleador:

- A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero con fondos en común de la lesión del empleado.
- El empleador/compañía aseguradora debe presentar un informe de accidente con la división dentro de 28 días a partir de la fecha de conocimiento del empleador acerca de la lesión.
- El empleador es requerido por el artículo de ley, K.S.A. 44-5, 102 (a) para entregar información al empleado o beneficiario legal inmediatamente para ayudar en el proceso de reclamos (material está disponible con la compañía aseguradora del empleador o en la División de Compensación de Trabajadores), incluyendo el formulario K-WC 27-A, o K-WC 270-A (español).

Responsabilidades del División de compensación de trabajadores:

- Hace el registro oficial de informes de accidentes presentados ante la División.

Beneficios para los Sobrevivientes

La ley de compensación de los trabajadores provee beneficios para sobrevivientes en caso de fallecimiento relacionado con el trabajo Los sobrevivientes no necesitan ser ciudadanos estadounidenses o residir en los Estados Unidos para recibir compensación.

Los beneficios semanales se basan en el 66.67 por ciento del salario semanal promedio del empleado en el momento del accidente o lesión, pero no pueden exceder el **máximo** legal El beneficio de fallecimiento mínimo es de 50 por ciento del salario semanal promedio del Estado en vigor en la fecha del accidente Los beneficios de compensación total no puede exceder la cantidad de 300,000 dólares, a menos que se les esté pagando beneficios a dependientes menores de 18 años. Los gastos de funeral hasta 5,000 dólares, así como todos los gastos médicos y de hospital relacionados con la lesión fatal también son cubiertos.

Un pago inicial de 40,000 dólares debe ser hecho al cónyuge legal sobreviviente o niño(s) completamente dependientes o dividido entre ellos, un 50 por ciento para el cónyuge legal y 50 por ciento al (los) niño(s) dependiente(s). Este pago de 40,000 dólares no está sujeto al ocho por ciento de descuento que normalmente es permitido en los pagos globales. El pago inicial deberá ser pagado inmediatamente.

Cónyuge e Hijos

Si un empleado es sobrevivido por un cónyuge pero sin hijos dependientes, el cónyuge recibe todo el beneficio seminal. Si un empleado es sobrevivido por un cónyuge e hijos dependientes, el beneficio semanal es pagado la mitad el cónyuge, y la otra mitad a los hijos dependientes. Si un empleado es sobrevivido solo por los hijos dependientes, el beneficio semanal es dividido en partes iguales entre los hijos.

Los hijos dependientes reciben beneficios hasta la edad de 18 años, o hasta la edad de 23 años si son estudiantes de tiempo completo o están mental o físicamente discapacitados, incluso si los beneficios superan el límite legal en el momento de la accidente. Donde es requerido, el empleador deberá pagar los costos de un conservador nombrado por un tribunal sin exceder la cantidad de 1,000 dólares.

Otros Dependientes

Si los beneficios de sobrevivientes son pagados al cónyuge y/o a los hijos dependientes, no pueden ser pagados a cualquier otro beneficiario. En el caso de un empleado soltero sin hijos dependientes, otro beneficiario, dependiente total o parcialmente del empleado puede recibir la compensación.

Los dependientes que no sean el cónyuge o hijos dependientes pueden percibir los beneficios semanales hasta un máximo de 18,500 dólares, o hasta que fallezcan, se casen o reciban más del 50 de su sustento de otra fuente.

Herederos Legales

Si el empleado no deja cónyuge, hijos dependientes u otros beneficiarios ya sea total o parcialmente dependientes del empleado, un pago único de 25,000 dólares deberá ser hecho a los herederos legales del empleado.

Condiciones que Afectan los Beneficios

Alcohol y Estupefacientes

Un empleador no es responsable de beneficios de compensación de trabajadores si un empleado está incapacitado debido al uso de alcohol* o estupefacientes** y la incapacidad contribuyó a la lesión o fallecimiento. Esto incluye el uso de medicamentos con o sin receta médica; sin embargo, los beneficios pueden ser permitidos, si:

- los fármacos o medicamentos fueron tomados en dosis terapéuticas; y
- el empleado no estado incapacitado en el trabajo por dichos medicamentos en los últimos 24 meses.

Si se demuestra que el empleado estaba incapacitado en el momento de la lesión, deberá haber una presunción refutable de que el accidente, lesiones, discapacidad o fallecimiento fueron contribuidos por dicha deficiencia.

Si el empleado rehúsa someterse a un examen químico a petición del empleador resultará en pérdida del derecho de beneficios bajo la ley de compensación de trabajadores, si el empleador tuviera suficientes motivos para sospechar el uso de alcohol o estupefacientes por el reclamante, o si la póliza del empleador autoriza claramente las pruebas después de una lesion.

Los resultados del examen químico deberán ser evidencia admisible para demostrar la incapacidad si el empleador establece que el examen se realizó bajo cualquiera de las siguientes circunstancias:

1. como resultado de una póliza del empleador por escrito, donde es obligatorio el examen para uso de estupefacientes, establecida antes de la fecha del accidente o lesión, requiriendo a cualquier trabajador que se someta a exámenes de estupefacientes o alcohol;
2. durante una autopsia o en el curso normal de tratamiento médico por motivos relacionados con la salud y el bienestar del trabajador lesionado y no a dirección del empleador;
3. el trabajador, antes de la fecha y hora del accidente o lesión, dio el consentimiento por escrito al empleador de que el trabajador se sometería voluntariamente a un examen químico de estupefacientes o alcohol seguido de cualquier accidente o lesión;
4. el trabajador acepta voluntariamente someterse a un examen químico de estupefacientes o alcohol después de cualquier accidente o lesión; o
5. como resultado de la ley federal o estatal, o norma federal o estatal o una regulación teniendo la fuerza y efecto de la ley, requiriendo un programa de pruebas después de la lesión y dicho programa requerido fue correctamente implementado en el momento de la prueba.

*Un empleado es considerado de estar incapacitado por uso de alcohol si la concentración de alcohol en la sangre es de 0.04 o más en el momento de la lesion.

** Niveles límite de prueba confirmatoria (ng/ml)

- Marihuana metabólica 15
- Cocaína metabólica 150
- Anfetaminas:
  - Anfetamina 500
  - Metanfetamina 500
- Opiáceos:
  - Morfina 2000
  - Codeína 2000
  - 6-Acetylmorphine 10ng/ml
  - Phencyclidine 25

Violaciones de Seguridad: K.S.A. 44-501(a) (1)

Compensación por una lesión deberá ser desaprobada si dicha lesión al empleado es el resultado de:

1. la intención deliberada del empleado de causar dichas lesiones;
2. falta intencionada del empleado de no utilizar una guarnición o protección contra accidentes o lesiones que es requerida en conformidad con cualquier estatuto y proporcionadas para el empleado;

3. falta intencionada del empleado para utilizar una razonable y adecuada guarnición y protección voluntariamente provista al empleado por el empleador;
4. violación de descuido del empleado de las normas o reglamentos de seguridad de su empleador o;
5. la participación voluntaria del empleado en peleas o bromas con un compañero de trabajo por cualquier motivo, relacionado con el trabajo o de otro tipo.

Lo anterior no deberá aplicar cuando era razonable bajo la totalidad de las circunstancias para no utilizar dicho equipo, o si el empleador aprobó en el trabajo comprometido en el momento de un accidente o lesión para ser realizado sin dicho equipo.

Enfermedad Coronaria y Derrame Cerebral

La ley no provee compensación por coronaria o enfermedad de la arteria coronaria o lesión cerebro-vascular (por ejemplo, derrame cerebral), a menos que se demuestre que el esfuerzo del trabajo que causó la lesión fue más allá de lo requerido por el trabajo habitual del empleado. Otra excepción es la lesión vascular causada por temperaturas extremas.

Previa Clasificación de Incapacidad/Condición Pre-existente

Compensación por cualquier incapacidad permanente puede ser reducida por la existencia de una clasificación en cualquier incapacidad pre-existente applicable.

K.S.A. 44-501(e): una adjudicación de compensación por incapacidad parcial permanente, incapacidad de trabajo o incapacidad total permanente deberá ser reducida por la cantidad de incapacidad funcional determinada a ser preexistente. Cualquier mencionada reducción no deberá aplicar a incapacidad total temporal, ni deberá aplicar a compensación por tratamiento medico.

K.S.A. 44-501(e)(1): donde beneficios de compensación de trabajadores han sido adjudicados previamente a través de un acuerdo o una determinación judicial administrativa en Kansas, las bases del porcentaje de previo acuerdo o adjudicación deberá establecer conclusivamente la cantidad de incapacidad funcional determinada a ser preexistente. Donde beneficios de compensación de los trabajadores no han sido previamente adjudicados a través de un acuerdo o determinación judicial o administrativa en Kansas, la cantidad de incapacidad funcional preexistente deberá ser establecida por evidencia competente.

Directrices para Obtener Tratamiento Médico

¿Quién Paga?

Los empleadores son responsables de todo tratamiento médico necesitado para una lesión o enfermedad relacionada con el trabajo. Esto incluye:

- servicios de un médico profesional con licencia;
- cirugías, hospital y otros tratamientos médicos;
- medicamentos, médicos y quirúrgicos suministrados;
- servicios de enfermería;
- muletas y otros aparatos médicos;
- servicios de ambulancia; y
- transporte entre el domicilio del empleado y el lugar de tratamiento médico, sujeto a un mínimo de cinco millas de viaje redondo.

Si un empleador tiene seguro de compensación de trabajadores, la compañía de seguros es requerida a pagar por gastos médicos aplicables. Los empleadores no asegurados sujetos a las leyes de compensación de trabajadores siguen siendo responsables de las facturas médicas de los trabajadores cubiertos.

Los empleadores tienen el derecho legal de elegir al médico del tratamiento. Si un empleado selecciona por sí mismo a un médico no autorizado o que no ha sido acordado con el empleador, el empleador es responsable solamente por los primeros 500 dólares en facturas médicas de dichos médicos seleccionados por el empleado.

Exámenes Ordenados por el Empleador

Después de obtener cualquier atención médica de emergencia necesaria, el empleado deberá someterse a cualquier examen físico razonable ordenado por el empleador. El empleador también puede requerir que el em-

pleado se someta a exámenes de continuo – hasta dos veces al mes, o más seguido si es específicamente ordenado por la División de Compensación de Trabajadores Los empleados pueden perder su derecho a beneficios que están disponibles si se niegan a someterse a dichos exámenes. Los empleados tienen derecho a conocer los resultados de cualquier examen físico ordenado por el empleador A petición del empleado, el doctor conduciendo el examen, debe proporcionar al empleado, dentro de un plazo razonable después del examen, un informe idéntico al que envió al empleador o compañía de seguros del empleador. Los empleados tienen derecho a tener su propio médico presente, y participar en cualquier examen médico ordenado por el empleador. Si esto no se permite, o si no se proporciona una copia del reporte médico a los empleados, entonces el examen ordenado por el empleador no será admitido como evidencia relacionada con el reclamo.

Fraude y Abuso

La División de Compensación de Trabajadores y el Departamento de Seguros de Kansas tienen unidades dedicadas la investigación de actos fraudulentos o abusivos y prácticas que ocurren con respecto a la Ley de compensación de trabajadores. Generalmente pueden ser actos o conductas que se consideran fraudulentas o abusivas descritos como situaciones en que los reclamantes, empleadores o empresas fallan o se niegan a seguir las directrices de la ley de compensación de trabajadores. La ley de compensación de trabajadores aplica a lo siguiente:

- personas reclamando beneficios bajo la Ley de Compensación de Trabajadores;
- los empleadores sujetos a los requisitos de la Ley de Compensación de Trabajadores;
- planes de aseguradoras y grupos mancomunados auto-asegurados, proporcionando cobertura para lesiones relacionadas con el trabajo;
- cualquier persona, empresa, negocio o clínica de salud proporcionando tratamiento para lesiones relacionadas con el trabajo;
- abogados y otros representantes de los empleadores, empleados, aseguradores o de otras entidades involucradas en la administración de la Ley de Compensación de Trabajadores.

Si el director o el fiscal adjunto asignado a la División de Compensación de Trabajadores, tiene causa probable para creer que un acto fraudulento o abusivo o práctica que viola la Ley de Compensación de Trabajadores ha ocurrido, una copia de cualquier orden y todos los informes de investigación y cualquier evidencia en la posesión de la División de Compensación de Trabajadores que se relaciona a dicha ley deberá remitirse al fiscal del condado en el que ocurrió el acto.

Cualquier persona que cree que se ha ocurrido una violación a la ley de Compensación de Trabajadores puede notificar a la División de Compensación de Trabajadores inmediatamente y debe enviar la información relativa a la presunta violación a la División El director deberá evaluar los hechos en torno a la supuesta violación para determinar en qué medida, si los hubiere, cuales violaciones de la Ley de Compensación de Trabajadores existe. Para obtener más información, llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe un correo electrónico a wcfraud@dol.ks.gov.

Cualquier persona que tenga una queja contra una compañía de seguros, o de otra persona/entidad regulada por Departamento de Seguros de Kansas, en relación con la tramitación de un reclamo de compensación de trabajadores, debe comunicarse con la División de lucha contra fraude en el Departamento de Seguros de Kansas Las quejas pueden hacerse llamando a los teléfonos (800) 432-2484 o (785) 296-3071, por escrito enviando información a la División de lucha contra fraude a 420 SW 9th St , Topeka, KS 66612 o en el internet en www.ksinsurance.org.

Cobertura y Cumplimiento de Normas

La sección de Cumplimiento supervisa y asiste a los empleadores para asegurar que cumplan con dos requisitos bajo la Ley de Compensación de trabajadores:

1. para proteger los beneficios de compensación de trabajadores para empleados y
2. para presentar informes por escrito de supuestos accidentes de trabajo.

Falta de asegurar beneficios de compensación de trabajadores o de reportar accidentes puede resultar en penas monetarias contra el empleador. Falta de asegurar beneficios de compensación a los trabajadores también puede resultar en la clausura del negocio.

De acuerdo con la ley K.S.A. 44-557, *es...la responsabilidad de cada empleador de hacer o causarque se haga un reporte a el director* de cualquier accidente, relamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones.*

Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en: http://www.dol.ks.gov/WorkComp/edinews.aspx.

Cuando el director tiene motivos para creer que un empleador ha incurrido en el conocimiento y falta intencional de asegurar el pago de compensación de Trabajadores a sus empleados, el director deberá emitir y entregar a tal empleador una declaración de los cargos y deberá conducir una audiencia de conformidad con la Ley de Procedimientos Administrativos del estado de Kansas. El empleador puede ser responsable ante el Estado por una pena civil en una cantidad igual a dos veces la prima anual o 25,000 dólares, cualquier cantidad que sea mayor.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A. R. 51-9-17.

El director deberá ordenar a los empleadores de entrar bajo la ley de Compensación de Trabajadores mediante:

1. asegurar y mantener asegurado el pago de dicha compensación con una compañía de seguros autorizada para tramitar las actividades de seguro de compensación de trabajadores en el estado de Kansas;
2. mostrando al director que el empleador porta ese riesgo propio y que es conocido por estar auto- asegurado y mediante proveer prueba al director de la capacidad financiera del empleador de pagar dicha compensación por sí mismo; o
3. manteniendo una membrecía en un grupo financiero de fondo común que sea cualificado El costo para proveer dicho seguro o riesgo deberá ser pagado por el empleador y no el empleado.

Para mas información llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe su correo electrónico a: **wccompliance@dol.ks.gov** o visite el sitio en internet **www.dol.ks.gov**.

Compruebe Cobertura

Usted puede comprobar si una empresa tiene cobertura de compensación de trabajadores en el internet. El sitio proporciona acceso al público a porciones de la información reportada por compañías aseguradoras privadas de compensación de trabajadores para uso del Departamento Laboral de Kansas (KDOL). La exactitud de los datos de cualquier tercer partido no puede ser garantizado por la agencia y KDOL no es responsable de la información de cobertura disponible a través de este enlace.

Para obtener ayuda adicional para verificar la cobertura de compensación de trabajadores en Kansas, llamar a Cobertura y cumplimiento de normas de la División de Compensación de Trabajadores al (785) 296-4000.

Servicios de Salud y Seguridad

La prevención de accidentes y seguridad en el lugar de trabajo es un elemento clave de la ley. Este requisito fue diseñado para reducir reclamos/pérdidas, lo que mantendría bajas las primas para los empleadores. Debido a

que las tarifas se basan en las pérdidas, la prevención de accidentes de los empleados, a través de medidas elevadas de seguridad, es una de las mejores maneras en que los empleadores pueden ayudar a mantener bajas las tasas de interés.

De acuerdo con la ley, las compañías de seguros y planes de grupos financieros deben proporcionar programas de prevención de accidente cuando sea solicitado por sus asegurados. Aviso de tales programas de prevención de accidentes debe aparecer en la portada de todas las pólizas emitidas después de julio de 1993.

Programas Ofrecidos por el Departamento Laboral de Kansas

Consulta: ofrece asistencia a los empleadores del sector privado en las evaluaciones del programa de salud y seguridad. Los consultores ofrecen asesoría en el reconocimiento, evaluación y control de riesgos laborales. Asistencia con la iniciación y el desarrollo del programa está disponible. Entrenamiento, formal e informal, es realizado en todas las áreas de salud y seguridad. Todos los servicios son sin costo al cliente.

Cumplimiento del Sector Público: supervisa al sector público – ciudades, condados, agencias estatales y distritos escolares – mediante la realización de auditorías de cumplimiento bajo el artículo K.S.A. 44-636 o K.S.A. 44-575(f). Se identifican los riesgos laborales y se evalúan los elementos del programa Los riesgos deben ser disminuidos dentro de 60 días. También se realizan investigaciones de quejas de empleados, accidentes leves y fatalidades.

Prevención de Accidentes: evalúa las compañías de seguros y planes de auto-seguro de grupo financiero para garantizar que están ofreciendo y proporcionando servicios de seguridad y salud sin costo para sus asegurados, como es requerido por la ley. La calidad y cantidad de estos servicios son evaluadas por consultores capacitados mediante revisar directamente los registros de la compañía de seguros y ponerse en contacto con aquellos que han solicitado y han recibido los servicios.

Asistencia en Prevención de Accidentes está disponible mediante correspondencia electrónica AccidentPrevention@dol.ks.gov. También puede encontrar información en linea en: www.dol.ks.gov/Safety/accident.aspx.

Conferencia de Salud y Seguridad: la Conferencia anual de Salud y Seguridad de Kansas reúne a los representantes del sector industrial, académico, proveedor y del Gobierno La Conferencia se lleva a cabo sin la ayuda de otros y trata de abordar las cuestiones relevantes de seguridad en una variedad de talleres y presentaciones.

Asistencia para salud y seguridad en el lugar de empleo está disponible llamando al (785) 296-4386 o envío de correo electrónico a indsafetyhealth@dol.ks.gov. Usted también puede encontrar información en el internet bajo Seguridad Laboral visitando www.dol.ks.gov.

Servicios de la Sección Ombudsman

La División de Compensación de trabajadores de Kansas estableció una Sección de Asesoramiento al Reclamante en el año de 1978 En 1993 la Legislatura siguió una tendencia nacional y, por ley, crearon el programa Ombudsman. La legislación de reforma de la compensación de los trabajadores en 1993 se ordenó una definición más amplia para la Sección de Consejeros para Reclamantes, facilitando el llevar un papel más activo para ayudar a todos los participantes a entender sus derechos y sus responsabilidades bajo la ley de Compensación para Trabajadores.

La División emplea personal de tiempo completo que se especializan en ayudar a los trabajadores lesionados, los empleadores y profesionales en seguros con información de reclamos y problemas derivados de accidentes de trabajo y enfermedades. El ombudsman actúa de manera imparcial y está disponible para proporcionar a los participantes información acerca de asuntos actualizados dentro del sistema de compensación de trabajadores. Por ejemplo, el ombudsman tiene información actualizada sobre cambios legislativos o modificaciones debido a decisiones tomadas por la Junta de compensación de trabajadores o del sistema legal. La sección de ombudsman también puede ayudar con temas específicos o reclamos actuales de compensación de trabajadores.

Ayudando a los trabajadores lesionados con:

- Proporcionando información general
- Obteniendo tratamiento médico

- Beneficios no pagados o no pagados oportunamente
- Beneficios médicos no pagados
- Cálculos de beneficios
- Notificación oportuna del empleador
- Procedimientos para la solicitud de una audiencia
- Obtención de beneficios de los sobrevivientes
- Resolución informal de disputas
- Asistencia de mediación
- Interpretación para los trabajadores de habla hispana

Ayudar a los empleadores/compañías de seguros:

- Proporcionando información general
- Exhibir el aviso de Compensación de Trabajadores (K-WC 40-A)
- Proporcionando información requerida a los trabajadores lesionados (K-WC 27-A/K-WC 270-A)
- Presentación oportuna de los reportes de accidentes
- Pago oportuno y adecuado de los servicios medicos
- Información de elecciones
- Asistencia con requisitos del beneficio por fallecimiento
- Resolución de disputa informal
- Asistencia con los trabajadores de habla hispana
- Capacitación del personal de empleador en cuestiones de compensación de trabajadores
- Visitas de asistencia práctica a los sitios de trabajo

Asistencia de un Ombudsman está disponible ya sea en persona o llamando al (785) 296-4000 o al (800) 332-0353. Usted también puede enviar un correo electrónico a wc@dol.ks.gov. Además, los formularios están disponibles para su descarga en www.dol.ks.gov.

Unidad de servicios al empleador Para asistencia técnica y presentaciones y capacitación para empleadores, llame al (785) 296-4000 o (800) 332-0353, o escriba al correo electrónico wcemployerservices@dol.ks.gov.

Mediación

La mediación fue legislativamente creada en 1996 (K.S.A. 44- 5,117) y puede ser utilizada en cualquier momento durante el proceso de compensación de trabajadores. El estatuto fue enmendado en 1998 para permitir la mediación por video conferencias. La mediación no es obligatoria o un requisito previo para una audiencia y puede ser utilizado en cualquier tiempo durante el proceso de compensación del trabajador. Los asuntos que se pueden mediar no se limitan a cuestiones de tratamiento médico o beneficios de incapacidad total temporal.

¿Qué es la Mediación?

La mediación es un medio de resolver los conflictos en un informal y no contencioso ambiente. El las partes en una controversia utilizan un tercer partido neutral para facilitar la discussion. El mediador no tiene ninguna autoridad haciendo decisiones o interés en el resultado del conflicto. El trabajo del mediador es ayudar a las partes involucradas para identificar las cuestiones en disputa y el establecimiento de objetivos communes. La clave de la mediación es que permite las partes involucradas a trabajar a través de su disputa y crear sus propios acuerdos.

¿Quiénes son los Mediadores?

Los mediadores son empleados de la División de Compensación de Trabajadores que han recibido especial capacitación en el proceso de mediación. Los mediadores utilizados por la División de compensación para trabajadores cumplen o superan los requisitos establecidos por K.S.A. 5-501 y enmiendas al mismo y cualquier

regla pertinente de la Corte Suprema de Kansas en conformidad con el artículo K.S.A. 5-510 y enmiendas. Los mediadores reciben capacitación en técnicas de resolución de conflictos, neutralidad, preparación de acuerdos, ética, desempeño como mediador, habilidades de comunicación, evaluación de casos y las leyes que rigen la mediación.

Representación y Asistencia

Cualquiera de los participantes podrá estar representado por un abogado en esta conferencia de mediación o podrá solicitar asistencia de la Sección Ombudsman/Consejeros de Reclamos. La ausencia de un abogado durante el proceso no significa que representación legal no puede obtenerse posteriormente si la disputa no se resuelve en este contexto informal.

Para obtener información adicional o para programar una conferencia de mediación, llame al (785) 296-4000 o (800) 332-0353 Escribir a la Sección de Mediación, Departamento Laboral de Kansas, División de Compensación de Trabajadores, 401 SW Topeka Boulevard, Topeka, KS 66603-3182 Puede enviar correo electrónico a wcmediation@dol.ks.gov.

Servicios Médicos

La función principal de la sección de Servicios Médicos es la administración de la programación de honorarios medicos. El programa de honorarios es actualizado y revisado anualmente para promover la contención del costo de salud, y todavía asegurar la disponibilidad de tratamiento necesario y cuidado para los empleados lesionados.

La sección de Servicios Médicos está disponible para actuar como un enlace entre los proveedores de atención médica, empleadores, empleados, aseguradoras, grupos financieros con fondo común o empresas auto-aseguradas Además, la sección conduce audiencias informales para ayudar en la resolución de reclamos médicos en disputa y pagos relacionados que envuelven a proveedores de atención médica.

Para obtener ayuda para resolver los problemas relacionados con interpretación de programación de tarifa, disputas de pago, etc., contacte la sección de servicios médicos al (785) 296-4000 o fax (785) 296-0025.

Rehabilitación Vocacional

Rehabilitación profesional podrá facilitarse a opción del empleador o de la aseguradora del empleador. La experiencia general ha demostrado que cuanto mayor sea el lapso de tiempo que el empleado esté fuera del trabajo en recuperación de una lesión, mayor será la probabilidad de que un empleado necesitará rehabilitación vocacional para reanudar trabajo adecuado a una remuneración comparable.

Si el empleador o la compañía de seguros no eligen proporcionar rehabilitación profesional, el empleado puede pedir al administrador de rehabilitación una referencia con un proveedor de dichos servicios a expensas del empleado. El empleado también puede solicitar una referencia a la División de Servicios de Rehabilitación en el Departamento de Servicios de Rehabilitación Social de Kansas.

Para obtener ayuda con la rehabilitación profesional, póngase en contacto con la oficina del administrador de rehabilitación en la División de Compensación de Trabajadores (800) 332-0353, (785) 296-4000 o envíe un correo electrónico a wcrehab@dol.ks.gov.

Departamento Laboral de Kansas
División de Compensación de Trabajadores

Departamento de Seguros de Kansas

NOTICE OF INSURED'S RIGHTS

If you are insured under a workers' compensation insurance policy and believe that the rates or the rating system have been incorrectly or improperly applied, you may request a review of the manner in which the rate or rating system has been applied. You must make your request in writing to the insurance company or advisory organization. The insurance company or advisory organization has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, the insurance company or advisory organization shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of the review. Your appeal is to be sent to:

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

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

MASSACHUSSETTS
BENEFITS DEDUCTIBLE PROGRAM
BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect the Massachusetts Benefits Deductible Program, you must make your election before the effective date of your next policy.

****

The second program, Massachusetts Benefits Claim and Aggregate Deductible Program, is intended for insureds who have the financial ability to handle some losses they incur, subject to an aggregate amount. This program will allow these insureds to elect an amount of loss per claim and an overall aggregate amount of all losses they can absorb and purchase insurance only for losses above those predetermined amounts. The amount of premium credit will vary by size of risk.

A medical and indemnity claim deductible of $2,500 and aggregate deductible amount of $10,000 shall be offered to every employer with a basis for the aggregate limit at policy inception not in excess of $200,000. Every employer with a basis for the aggregate limit of $200,000 and greater shall be offered a medical and indemnity claim deductible of $2,500 and an aggregate deductible amount of 5% of basis for the aggregate limit. The Aggregate Deductible amount and corresponding Premium Reduction Credit may change according to the level of final premium calculated at time of audit. The $2,500 claim deductible amount shall apply separately to each claim for bodily injury by accident or disease, subject to the aggregate deductible amount. The insurer shall pay all benefits required under the provisions of law directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the $2,500 deductible limit on any claim, the insurer shall seek reimbursement from the policyholder. The aggregate deductible amount is the most that the policyholder must reimburse the insurer for the sum of all medical and indemnity benefits compensable under law for each policy period. Failure to make complete reimbursement for deductibles within 30 days of receipt of a bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect the Massachusetts Benefits Claim and Aggregate Deductible Program, you must make your election before the effective date of your policy.

****

Please contact your producer or insurance company representative promptly for additional information, including the premium credit amounts which apply under these programs.

NOTICE TO MICHIGAN POLICYHOLDERS

THIS POLICY IS EXEMPT FROM THE FILING REQUIREMENTS OF SECTION 2236 OF THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.2236.

IMPORTANT NOTICE TO MINNESOTA POLICYHOLDERS

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

Dear Policyholder:

In the event you need to contact someone about this policy for any reason, please contact your agent. If you need additional assistance, you may contact us at the address and telephone number indicated below:

INSURANCE COMPANY

TRAVELERS CASUALTY COMPANY OF CONNECTICUT

One Tower Square
Hartford, CT 06183
1-888-661-3938

PRODUCER/AGENT

Name: **RIGGS COUNSELMAN MICHAEL**

Address: **555 FAIRMOUNT AVE**
TOWSON, MD 212865417

Phone Number: **484-581-2800**

Thank you for insuring with Travelers.

MISSISSIPPI

AVAILABILITY OF SAFETY PROGRAM

A sample Safety Program is available to you upon request which contains templates of the following basic elements to allow you to build a customized Safety Program for your business:

1. **Safety Policy**
2. **Safety Training**
3. **Safety Meetings**
4. **Preventive Maintenance**
5. **Safety Inspections**
6. **First Aid Procedures**
7. **Accident Investigations and Record Keeping**
8. **Workplace Safety Rules**

Also included is information on employee's rights under the Workers' Compensation Law, Miss. Code Ann. §71-3-1, et seq., and the Rules of the Mississippi Workers' Compensation Commission which you may make readily available to your employees.

Information is also included regarding your right as an employer to implement and maintain a written policy for drug and alcohol testing in the workplace so long as it complies with the requirements of Miss. Code Ann. §71-7-1 et seq. and the rules and regulations for drug and alcohol testing of employees and job applicants by public and private employers promulgated by the Mississippi State Board of Health. Pursuant to §71-7-1, et seq., the election of a public or private employer to conduct drug and alcohol testing is voluntary.

If you would like to request the sample Safety Program described above, please call us at 800-973-9215, or for further information on our other Risk Control services and materials that are available, log in at www.travelers.com. Not registered? Select "Log In" and then "Register Now" to register for MyTravelers for Business.

IMPORTANT NOTICE – CONTACT INFORMATION – MISSOURI

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

Questions regarding your policy or coverage should be directed to your agent or us at:

Travelers Indemnity Company
One Tower Square
Hartford, CT 06183

1-800-328-2189

Questions regarding policies written through the Missouri Alternate Residual Market Plan should be directed to:

Travelers Property Casualty Company of America
940 Westport Plaza, Suite 300
St. Louis, MO 63146

1-800-842-9346

IMPORTANT NOTICE TO NEVADA POLICYHOLDERS

Dear Policyholder:

Nevada law requires that you complete form C-3 within six (6) days from the receipt of the report of initial treatment (form C-4). Form C-3 should be forwarded to our Claim Department. Failure to timely complete form C-3 may result in administrative fines to you in the amount of $1,000 per violation.

For additional information please contact us at 1-800-832-7839.

"For your convenience, the following is the applicable statutory language."

AC616A.480 Use, alteration, printing and distribution of certain posters and forms.

1. The following posters and forms or data must be used by an insurer, employer, injured employee, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation:

(d) C-3, Employer's Report of Industrial Injury or Occupational Disease. A copy of the form must be delivered to or the form must be filed by electronic transmission with the insurer or third-party administrator. The form signed by the employer must be retained by the employer. A copy of the form must be delivered to the injured employee. If the employer files the form by electronic transmission, the employer must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the employer that is:

i. Unique to the employer;

ii. Capable of verification; and

iii. Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original report of industrial injury or occupational disease for 3 years. If the employer moves from or ceases operation in this state, the employer shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of operation.

3. The forms listed in this section must be accurately completed, including, without limitation, a signature and a date if required by the form. An insurer or employer may designate a third-party administrator as an agent to sign any form listed in this section.

NRS 616C.045 Report of industrial injury or occupational disease: Duty of employer to file; electronic filing; form and contents; penalty.

1. Except as otherwise provided in NRS 616B.727, within 6 working days after the receipt of a claim for compensation from a physician or chiropractor, an employer shall complete and file with his insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be on a form prescribed by the administrator;

(b) Be signed by the employer or his designee;

(c) Contain specific answers to all questions required by the regulations of the administrator; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician or chiropractor indicates that the injured employee is expected to be off work for 5 days or more.

3. An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or his designee. The form must be mailed with 7 days after receiving such a request.

4. The administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.

IMPORTANT NOTICE –
NEW HAMPSHIRE MANAGED CARE PROGRAMS

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

New Hampshire Certified Managed Care Programs are programs that have been approved by the New Hampshire Department of Labor and ratified by the New Hampshire Advisory Council on Workers Compensation.

To receive the benefits of the New Hampshire Certified Managed Care Programs, you must contact your insurance carrier or subscribe individually to the programs.

TRAVELERS

IMPORTANT NOTICE – PENALTY FOR AUDIT NONCOMPLIANCE – NEW HAMPSHIRE

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

The New Hampshire Governor signed into law House Bill 1245, which takes effect September 27, 2020. This bill establishes an audit noncompliance penalty charge equal to three times the estimated annual premium for failure to cooperate with the completion of the final audit. Unless there is a dispute, failure to cooperate within thirty days of the audit notification shall result in the penalty charge. Upon receipt of the penalty and final premium, you shall have an additional 10 days to request that the penalty be waived and to have the final premium be recalculated based upon actual exposure that has been provided by completing the audit that is required by law.

As a result of this new law, a New Hampshire Audit Noncompliance Charge Endorsement (WC 28 04 05) is being attached your policy. This endorsement replaces any reference to an audit noncompliance charge for New Hampshire exposure in the current Audit Noncompliance Endorsement (WC 00 04 24) and applies to new and renewal policies effective on and after September 27, 2020, as well as policies in force as of September 27, 2020.

IMPORTANT NOTICE TO NEW YORK POLICYHOLDERS

If you have New York employees meeting either of the following conditions, you must take action to obtain a specific posting notice:

1. If you own or operate an automotive or horse drawn vehicle, and have no minimum staff of regular employees who are required to report for work at your established place or business; or
2. If you engage in the business of moving household goods or furniture.

If you meet either of these conditions, New York statute requires you to post and maintain notice C-105.1 in every vehicle owned or operated by you. New York may fine you $250 for each violation.

Please contact your agent and request the number of copies of this notice that you need. A sample copy of the notice is included.

State of New York
WORKERS' COMPENSATION BOARD

SAMPLE COPY

PRESCRIBED COPY
Form C-105.1

Notice to be Posted by Employer Under NY WCL Section 51
for Automotive or Horse-Drawn Vehicles

Color: White
Size: 6" X 4"
Stock: Index or Ledger

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

The undersigned employer hereby gives notice that he/she has conformed to the provisions of the Workers' Compensation Law and the rules of the Workers' Compensation Board of the State of New York, and that he/she has secured the payment of compensation to his/her employees, and the dependents of employees, engaged in employments enumerated in or brought within the provisions of said law. Such compensation has been secured for such employees in accordance with Section 50 of the Workers' Compensation Law, by insuring with:

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer:

Policy No.....Policy in Force from .....to .....
(For Insurance Carriers Only)

..... By .....
Legal Name of Insured (Employer) Signature of Employer

Failure by an employer to post this notice in an automotive or horse-drawn vehicle as required by NY WCL Section 51, or in every veh icle used to move household goods or services, may result in a $250 penalty for each violation.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND
C-105.1 (9-05) SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

Section 51 of the NYS Workers' Compensation Law

Every employer who has complied with section fifty of this article shall post and maintain in a conspicuous place or places in and about his place or places of business typewritten or printed notices in form prescribed by the chairman, stating the fact that he has complied with all the rules and regulations of the chairman and the board and that he has secured the payment of compensation to his employees and their dependents in accordance with the provisions of this chapter, but failure to post such notice as herein provided shall not in any way affect the exclusiveness of the remedy provided for by section eleven of this chapter. Every employer who owns or operates automotive or horse-drawn vehicles and has no minimum staff of regular employees required to report for work at an established place of business maintained by such employer and every employer who is engaged in the business of moving household goods or furniture shall post such notices in each and every vehicle owned or operated by him. Failure to post or maintain such notice in any of said vehicles shall constitute presumptive evidence that such employer has failed to secure the payment of compensation. The chairman may require any employer to furnish a written statement at any time showing the stock corporation, mutual corporation or reciprocal insurer in which such employer is insured or the manner in which such employer has complied with any provision of this chapter. Failure for a period of ten days to furnish such written statement shall constitute presumptive evidence that such employer has neglected or failed in respect of any of the matters so required. Any employer who fails to comply with the provisions of this section shall be required to pay to the board a fine of up to two hundred fifty dollars for each violation, in addition to any other penalties imposed by law to be deposited into the uninsured employers' fund.

C-105.1 Reverse (9-05)

PN T4 91 01 06
W31M5D06

State of New York
Determination of Classification Change from 10/1/2023 to 10/1/2024 Rates

Company Name	Company Abbreviation	Company LCM
The Charter Oak Fire Insurance Company	COF	1.025
The Travelers Indemnity Company of America	TIA	1.140
The Travelers Indemnity Company of Connecticut	TCT	1.207
The Travelers Indemnity Company	IND	1.274
Travelers Casualty and Surety Company	ACR	1.341
Travelers Property Casualty Company of America	TIL	1.081
Travelers Casualty Insurance Company of America	ACJ	1.408
The Phoenix Insurance Company	PHX	1.475

Notes: "If you were insured with a **different carrier** last year, compare the current loss costs and multiplier to those used by your prior carrier."

To obtain the classification percentage change, multiply the loss cost classification percentage change in the attached pages by the change in LCM based on the writing company LCM and policy effective date found in the above table. Divide your Proposed Company LCM by your Prior Company LCM. (Small differences may exist due to rounding).

Example:

This example assumes a proposed effective date of 10/1/2024 (effective date of previous policy term was 10/1/2023).

Prior Company: TIL
Proposed Company: TIL
Class Code: 2913

Take the change in decimal form for class 2913 from the attached pages (loss cost comparison) which is 0.777 (-0.223+1.000). Then multiply by the company LCM change (Proposed Company LCM / Prior Company LCM).

(0.777) x (1.081 / 1.081) = 0.777 (-22.3%)

which indicates a 22.3% decrease from the October 2023 rate. If the result of the multiplication was greater than 1.000, then the result is an increase. If the result of the multiplication is less than 1.000; this implies a decrease.

NEW YORK WORKERS' COMPENSATION

OCTOBER 1, 2024 LOSS COST REVISION

EXPLANATORY MEMORANDUM

An overall loss cost decrease of 9.0%, which includes a decrease of 9.2% in the average manual loss cost level and no change in the loss cost provision for terrorism, natural disasters and catastrophic industrial accidents, has been approved by the New York State Department of Financial Services to become effective on October 1, 2024.

The following is a description of the various components of the approved change:

Loss Experience – The latest two policy years of experience produced a decrease of 7.2% in the overall loss cost level.

Legislative Changes – This revision includes the estimated cost impacts of both the latest increases in the maximum weekly benefits that were set forth in the 2007 workers' compensation reform legislation, as well as the increases in the minimum weekly benefits that were signed into law on September 6, 2023. This component contributed an increase of 2.3% to the overall change.

Loss Adjustment Expenses – A review of the latest data available resulted in an increase of 1.7% in the Loss Adjustment Expense provision.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a slight decrease in claim frequency, and mild upward trends in both indemnity and medical claim costs. Combined with a projected wage trend, the final selected net trend factor is -5.9%.

Catastrophe Provision – This revision contains no changes in the loss cost provisions for terrorism and for natural disasters and catastrophic industrial accidents.

Classification Loss Costs – Although the average manual loss cost level is decreasing by 9.2%, individual classification loss cost changes are based on the most recently available loss experience for each classification. Both increases and decreases from the current loss costs have been actuarially calculated for each class. This process ensures that each classification loss cost reflects the appropriate level relative to the experience of the other classifications.

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
0005	1.11	1.29	-14.0%	2089	3.89	4.92	-20.9%
0006	1.60	1.81	-11.6%	2095	4.37	4.62	-5.4%
0007	1.00	1.27	-21.3%	2101	5.03	6.04	-16.7%
0031	1.28	1.54	-16.9%	2105	2.63	3.22	-18.3%
0034	2.50	3.14	-20.4%	2111	1.81	1.77	2.3%
0035	1.73	2.09	-17.2%	2112	4.10	4.95	-17.2%
0042	3.11	3.82	-18.6%	2114	5.79	7.14	-18.9%
0050	1.32	1.71	-22.8%	2121	3.96	4.51	-12.2%
0106	4.65	4.83	-3.7%	2143	2.37	2.63	-9.9%
0251	10.51	11.66	-9.9%	2150	8.83	8.60	2.7%
0771	8.36	8.53	-2.0%	2157	8.18	9.83	-16.8%
0908	119.97	131.06	-8.5%	2172	3.51	3.86	-9.1%
0909	190.47	193.30	-1.5%	2288	3.64	4.33	-15.9%
0912	903.08	1083.12	-16.6%	2302	2.62	2.66	-1.5%
0913	467.07	453.91	2.9%	2362	1.86	1.93	-3.6%
0917	3.34	3.25	2.8%	2380	3.87	4.32	-10.4%
1170	2.19	2.64	-17.0%	2387	2.96	3.49	-15.2%
1320	2.67	3.36	-20.5%	2388	1.72	2.14	-19.6%
1430	1.77	2.15	-17.7%	2402	1.39	1.69	-17.8%
1438	7.81	10.31	-24.2%	2413	2.35	2.85	-17.5%
1439	2.85	3.14	-9.2%	2417	1.99	2.13	-6.6%
1452	6.21	7.68	-19.1%	2501	0.65	0.74	-12.2%
1463	4.28	4.50	-4.9%	2503	0.58	0.68	-14.7%
1470	5.07	6.72	-24.6%	2553	1.87	1.77	5.6%
1624	2.33	3.07	-24.1%	2570	2.58	2.87	-10.1%
1701	3.51	4.08	-14.0%	2571	2.35	2.72	-13.6%
1710	6.18	5.84	5.8%	2576	3.25	3.14	3.5%
1741	6.28	8.28	-24.2%	2590	1.73	2.03	-14.8%
1747	7.07	9.33	-24.2%	2591	3.56	4.17	-14.6%
1748	6.27	7.17	-12.6%	2593	3.74	4.41	-15.2%
1809	10.63	10.05	5.8%	2594	4.16	5.03	-17.3%
1810	4.46	5.19	-14.1%	2600	5.75	6.03	-4.6%
1860	3.27	3.87	-15.5%	2623	2.15	2.49	-13.7%
1924	2.12	2.57	-17.5%	2640	11.68	11.90	-1.8%
1925	4.03	5.14	-21.6%	2660	1.59	1.75	-9.1%
2001	2.02	2.60	-22.3%	2670	2.16	3.20	-32.5%
2002	3.65	4.12	-11.4%	2683	3.30	3.81	-13.4%
2003	4.42	4.82	-8.3%	2688	1.16	1.27	-8.7%
2014	3.57	4.33	-17.6%	2689	1.00	0.87	14.9%
2021	2.95	3.45	-14.5%	2702	7.30	8.85	-17.5%
2039	4.91	6.22	-21.1%	2710	2.23	2.94	-24.1%
2041	2.42	2.72	-11.0%	2714	4.42	5.16	-14.3%
2065	3.06	2.98	2.7%	2731	2.94	3.33	-11.7%
2070	3.76	4.45	-15.5%	2737	4.81	5.30	-9.2%
2081	3.85	5.29	-27.2%	2759	5.00	6.07	-17.6%

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
2790	0.95	1.03	-7.8%	3257	1.99	2.38	-16.4%
2802	3.99	4.11	-2.9%	3270	1.56	1.52	2.6%
2817	2.92	3.11	-6.1%	3307	1.72	2.01	-14.4%
2835	1.54	1.83	-15.8%	3315	13.24	13.50	-1.9%
2841	3.03	3.71	-18.3%	3336	1.42	1.71	-17.0%
2881	2.18	2.45	-11.0%	3365	5.23	6.47	-19.2%
2883	2.66	2.60	2.3%	3372	2.74	2.93	-6.5%
2913	3.76	4.84	-22.3%	3381	0.75	1.13	-33.6%
2916	2.22	2.92	-24.0%	3383	0.38	0.42	-9.5%
2923	3.59	3.40	5.6%	3384	0.33	0.29	13.8%
3004	2.90	3.34	-13.2%	3385	0.50	0.64	-21.9%
3018	7.69	7.56	1.7%	3400	5.65	7.20	-21.5%
3022	3.48	4.57	-23.9%	3507	3.10	3.35	-7.5%
3027	1.33	1.71	-22.2%	3515	2.14	2.63	-18.6%
3028	5.15	5.32	-3.2%	3548	1.90	1.89	0.5%
3030	7.65	7.56	1.2%	3559	3.11	3.80	-18.2%
3040	7.30	7.25	0.7%	3574	0.77	0.93	-17.2%
3041	3.94	4.44	-11.3%	3581	1.25	1.38	-9.4%
3042	3.45	3.60	-4.2%	3612	2.55	2.59	-1.5%
3060	4.57	5.73	-20.2%	3620	3.46	3.76	-8.0%
3064	3.63	3.85	-5.7%	3629	1.11	1.32	-15.9%
3066	2.98	3.19	-6.6%	3632	2.35	2.33	0.9%
3067	2.83	2.93	-3.4%	3634	1.42	1.56	-9.0%
3076	2.38	2.49	-4.4%	3635	1.03	1.19	-13.4%
3081	4.03	4.00	0.8%	3638	1.54	1.81	-14.9%
3085	4.16	5.49	-24.2%	3642	0.68	0.86	-20.9%
3110	3.92	4.95	-20.8%	3643	2.09	2.29	-8.7%
3111	2.22	2.67	-16.9%	3647	3.76	3.85	-2.3%
3113	1.50	1.79	-16.2%	3648	1.94	2.12	-8.5%
3114	1.37	1.65	-17.0%	3681	0.85	0.96	-11.5%
3118	1.70	1.94	-12.4%	3685	1.13	1.27	-11.0%
3122	4.68	5.06	-7.5%	3686	1.24	1.36	-8.8%
3129	2.94	3.42	-14.0%	3724	3.59	3.65	-1.6%
3132	1.43	1.66	-13.9%	3726	3.36	3.45	-2.6%
3145	1.73	2.04	-15.2%	3737	3.45	3.94	-12.4%
3146	1.16	1.32	-12.1%	3807	2.87	3.44	-16.6%
3169	2.93	3.40	-13.8%	3808	2.57	3.34	-23.1%
3179	1.42	1.71	-17.0%	3821	4.13	4.92	-16.1%
3188	2.42	2.53	-4.3%	3823	3.23	3.59	-10.0%
3190	1.99	2.52	-21.0%	3824	3.99	4.50	-11.3%
3191	1.41	1.72	-18.0%	3826	1.06	1.25	-15.2%
3200	1.79	2.35	-23.8%	3827	2.64	2.98	-11.4%
3220	2.11	2.19	-3.7%	3830	1.04	1.13	-8.0%
3227	22.43	23.66	-5.2%	3832	1.76	1.97	-10.7%
3241	4.83	5.10	-5.3%	3865	2.06	2.26	-8.8%

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
3881	2.30	2.54	-9.4%	4511	0.57	0.66	-13.6%
4000	3.31	4.36	-24.1%	4557	1.03	1.01	2.0%
4024	4.98	6.50	-23.4%	4558	2.30	2.73	-15.8%
4034	5.27	6.48	-18.7%	4568	1.85	2.11	-12.3%
4038	1.71	2.06	-17.0%	4583	5.11	6.34	-19.4%
4053	1.93	2.33	-17.2%	4597	1.17	1.30	-10.0%
4061	2.03	2.15	-5.6%	4611	1.57	1.69	-7.1%
4062	5.43	6.26	-13.3%	4628	1.23	1.63	-24.5%
4101	2.53	2.46	2.8%	4635	4.57	6.26	-27.0%
4111	2.29	2.17	5.5%	4653	3.84	4.46	-13.9%
4112	0.74	0.91	-18.7%	4665	8.52	9.71	-12.3%
4114	1.82	1.95	-6.7%	4692	0.72	0.80	-10.0%
4130	3.93	4.15	-5.3%	4693	1.82	1.94	-6.2%
4133	2.89	2.93	-1.4%	4710	1.42	1.43	-0.7%
4150	1.01	1.11	-9.0%	4712	2.41	2.35	2.6%
4207	0.66	0.77	-14.3%	4720	1.91	2.06	-7.3%
4239	2.49	2.64	-5.7%	4751	1.31	1.61	-18.6%
4240	2.18	2.76	-21.0%	4771	1.75	2.24	-21.9%
4243	2.52	2.84	-11.3%	4825	0.46	0.63	-27.0%
4244	2.58	2.82	-8.5%	4828	2.00	2.34	-14.5%
4250	2.48	2.44	1.6%	4829	1.48	2.03	-27.1%
4251	1.53	1.72	-11.0%	4902	1.34	1.76	-23.9%
4263	3.70	3.50	5.7%	4923	0.85	1.00	-15.0%
4273	2.67	2.90	-7.9%	5000	8.78	8.20	7.1%
4279	3.13	3.31	-5.4%	5022	16.03	16.47	-2.7%
4282	0.25	0.27	-7.4%	5037	23.34	26.28	-11.2%
4299	1.69	1.90	-11.1%	5040	15.13	17.55	-13.8%
4304	8.67	9.18	-5.6%	5057	6.81	8.65	-21.3%
4307	1.89	2.36	-19.9%	5059	12.54	16.26	-22.9%
4312	2.16	2.63	-17.9%	5102	10.04	11.43	-12.2%
4351	1.78	2.06	-13.6%	5160	4.11	4.28	-4.0%
4352	0.46	0.51	-9.8%	5183	5.02	5.66	-11.3%
4360	0.27	0.30	-10.0%	5184	5.46	5.70	-4.2%
4361	0.44	0.44	0.0%	5188	4.28	4.66	-8.2%
4362	0.29	0.32	-9.4%	5190	3.89	4.39	-11.4%
4410	3.37	4.39	-23.2%	5191	1.17	1.14	2.6%
4420	6.50	8.58	-24.2%	5192	4.23	4.66	-9.2%
4431	3.15	3.44	-8.4%	5193	6.72	6.28	7.0%
4432	1.44	1.62	-11.1%	5213	19.40	19.15	1.3%
4452	1.98	2.49	-20.5%	5221	11.17	11.37	-1.8%
4459	2.77	3.18	-12.9%	5222	8.01	10.31	-22.3%
4470	3.23	3.76	-14.1%	5223	4.49	5.51	-18.5%
4475	1.71	2.01	-14.9%	5348	6.89	7.12	-3.2%
4476	1.69	1.83	-7.7%	5402	3.33	3.66	-9.0%
4493	2.82	3.28	-14.0%	5403	13.22	13.26	-0.3%

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
5428	6.24	7.32	-14.8%	6801	24.36	23.74	2.6%
5429	5.10	6.11	-16.5%	6811	3.97	4.04	-1.7%
5443	10.24	9.56	7.1%	6824	7.09	9.25	-23.4%
5445	7.72	9.11	-15.3%	6826	2.14	2.57	-16.7%
5462	6.59	6.47	1.9%	6834	2.34	2.74	-14.6%
5473	22.48	27.82	-19.2%	6836	1.99	2.54	-21.7%
5474	10.10	10.23	-1.3%	6843	6.81	8.07	-15.6%
5479	4.46	5.12	-12.9%	6854	2.08	2.46	-15.4%
5480	10.78	10.07	7.1%	6872	7.74	8.63	-10.3%
5491	1.98	1.85	7.0%	6874	29.59	33.21	-10.9%
5506	9.98	12.94	-22.9%	6875	64.98	72.37	-10.2%
5507	5.29	6.86	-22.9%	6882	11.63	11.34	2.6%
5508	3.17	2.96	7.1%	6884	32.17	37.65	-14.6%
5536	4.57	4.98	-8.2%	6885	46.37	54.06	-14.2%
5538	7.15	6.68	7.0%	7016	8.51	11.59	-26.6%
5545	13.81	17.18	-19.6%	7024	9.45	12.87	-26.6%
5547	6.27	7.55	-17.0%	7038	2.33	2.90	-19.7%
5606	2.97	3.15	-5.7%	7046	2.07	2.42	-14.5%
5610	10.02	9.36	7.1%	7047	18.43	24.51	-24.8%
5645	5.25	6.60	-20.5%	7050	5.04	6.14	-17.9%
5648	9.90	12.40	-20.2%	7090	2.58	3.23	-20.1%
5651	5.01	6.50	-22.9%	7098	2.30	2.69	-14.5%
5701	14.55	13.59	7.1%	7099	4.48	5.12	-12.5%
5703	8.64	9.98	-13.4%	7133	3.89	3.68	5.7%
5709	23.94	22.35	7.1%	7197	5.43	6.54	-17.0%
5951	0.38	0.47	-19.1%	7201	1.89	2.28	-17.1%
6003	8.89	8.30	7.1%	7207	2.23	2.85	-21.8%
6005	4.09	4.42	-7.5%	7219	7.74	9.38	-17.5%
6017	3.23	3.51	-8.0%	7231	7.00	9.08	-22.9%
6018	7.37	7.31	0.8%	7309	3.53	3.44	2.6%
6045	3.94	3.95	-0.3%	7313	1.73	1.91	-9.4%
6204	5.27	6.17	-14.6%	7317	15.72	18.01	-12.7%
6216	4.94	6.41	-22.9%	7327	16.80	20.66	-18.7%
6217	4.50	5.23	-14.0%	7333	4.57	5.36	-14.7%
6229	3.18	3.42	-7.0%	7335	5.08	5.95	-14.6%
6233	2.38	3.08	-22.7%	7337	9.91	11.33	-12.5%
6235	4.37	5.66	-22.8%	7364	0.41	0.40	2.5%
6251	13.70	14.94	-8.3%	7366	4.52	4.41	2.5%
6252	1.83	2.15	-14.9%	7367	5.44	5.78	-5.9%
6306	5.46	6.17	-11.5%	7368	4.30	5.39	-20.2%
6319	3.12	3.75	-16.8%	7370	(c)	(c)	-11.3%
6325	3.77	4.58	-17.7%	7377	3.54	4.85	-27.0%
6400	6.19	6.26	-1.1%	7380	7.19	7.77	-7.5%
6504	3.04	3.40	-10.6%	7390	11.32	12.36	-8.4%
6701	13.77	13.66	0.8%	7394	2.86	3.65	-21.6%

(c) Refer to Miscellaneous Values in the manual for loss costs.

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
7395	3.18	4.05	-21.5%	8046	2.17	2.34	-7.3%
7398	6.19	7.52	-17.7%	8047	1.49	1.44	3.5%
7403	4.65	5.68	-18.1%	8048	3.20	3.77	-15.1%
7405	0.94	1.16	-19.0%	8068	0.09	0.11	-18.2%
7421	0.33	0.43	-23.3%	8069	0.20	0.26	-23.1%
7422	1.04	1.12	-7.1%	8072	0.50	0.57	-12.3%
7431	0.39	0.51	-23.5%	8090	0.56	0.63	-11.1%
7445	0.19	0.22	-13.6%	8102	3.67	4.07	-9.8%
7453	0.18	0.21	-14.3%	8103	3.01	3.27	-8.0%
7502	1.90	2.39	-20.5%	8105	1.39	1.64	-15.2%
7515	1.40	1.84	-23.9%	8106	4.26	5.53	-23.0%
7520	4.53	5.03	-9.9%	8107	2.54	2.81	-9.6%
7536	10.22	9.78	4.5%	8111	2.76	3.52	-21.6%
7538	2.44	3.16	-22.8%	8116	1.32	1.41	-6.4%
7539	1.05	1.15	-8.7%	8199	2.81	3.72	-24.5%
7542	2.71	2.74	-1.1%	8209	3.04	4.05	-24.9%
7580	2.05	2.50	-18.0%	8215	2.25	2.78	-19.1%
7590	6.41	7.01	-8.6%	8227	7.75	9.05	-14.4%
7600	6.50	6.43	1.1%	8232	4.62	5.02	-8.0%
7601	2.92	3.78	-22.8%	8235	3.44	3.94	-12.7%
7610	0.19	0.20	-5.0%	8263	4.11	4.54	-9.5%
7710	3.17	4.17	-24.0%	8264	4.37	5.17	-15.5%
7711	(e)	(e)	-21.5%	8265	4.35	5.76	-24.5%
7716	(e)	(e)	-21.5%	8280	9.97	11.08	-10.0%
7720	2.27	2.84	-20.1%	8288	2.81	3.62	-22.4%
7723	1.22	1.32	-7.6%	8291	5.84	6.18	-5.5%
7855	6.61	6.65	-0.6%	8292	3.39	4.33	-21.7%
7998	1.95	1.88	3.7%	8293	6.09	7.02	-13.2%
7999	1.78	1.87	-4.8%	8350	7.12	9.01	-21.0%
8001	1.75	1.82	-3.8%	8353	5.02	5.74	-12.5%
8006	1.24	1.40	-11.4%	8381	1.13	1.45	-22.1%
8008	0.75	0.84	-10.7%	8382	1.14	1.35	-15.6%
8013	0.24	0.23	4.3%	8385	8.02	10.20	-21.4%
8016	0.49	0.50	-2.0%	8391	2.08	2.38	-12.6%
8017	1.00	1.11	-9.9%	8392	2.17	2.29	-5.2%
8018	3.01	3.30	-8.8%	8394	4.10	4.41	-7.0%
8021	4.27	4.94	-13.6%	8500	3.69	4.89	-24.5%
8025	0.96	0.92	4.3%	8601	0.33	0.40	* -17.5%
8031	1.54	1.69	-8.9%	8709	17.78	19.51	-8.9%
8032	0.71	0.82	-13.4%	8719	1.44	1.68	-14.3%
8033	2.57	2.87	-10.5%	8720	1.43	1.46	-2.1%
8034	4.40	4.40	0.0%	8723	0.10	0.10	0.0%
8039	1.65	1.83	-9.8%	8726	1.43	1.50	-4.7%
8043	0.91	0.97	-6.2%	8731	1.58	1.54	2.6%
8044	2.90	2.98	-2.7%	8742	0.20	0.22	-9.1%

(e) Refer to Volunteer Firefighters schedule for loss costs. Loss cost change is the same for all population groups in this class.

* Class Code 8601 has been broadened to include “clerical office employees” effective 10/1/2024. Please refer to R.C. Bulletin #2606 for further information.

Workers' Compensation - New York

Loss Cost Comparison - October 1, 2023 to October 1, 2024

Class Code	Oct. 2024	Oct. 2023	% Change	Class Code	Oct. 2024	Oct. 2023	% Change
8745	3.34	3.64	-8.2%	9059	6.42	7.90	-18.7%
8747	0.17	0.18	-5.6%	9060	1.09	1.16	-6.0%
8748	0.62	0.75	-17.3%	9061	1.23	1.52	-19.1%
8751	2.38	2.92	-18.5%	9063	0.72	0.82	-12.2%
8755	0.74	0.72	2.8%	9065	0.81	0.87	-6.9%
8800	1.82	1.78	2.2%	9071	1.15	1.30	-11.5%
8802	1.03	0.93	10.8%	9072	1.18	1.34	-11.9%
8803	0.03	0.03	* 0.0%	9074	0.69	0.81	-14.8%
8809	0.15	0.14	7.1%	9088	5.65	6.73	-16.0%
8810	0.10	0.10	0.0%	9089	0.23	0.26	-11.5%
8813	0.10	0.10	** 0.0%	9093	0.74	0.79	-6.3%
8820	0.08	0.09	-11.1%	9101	2.16	2.33	-7.3%
8829	2.88	3.22	-10.6%	9102	2.29	2.61	-12.3%
8831	0.83	1.02	-18.6%	9149	0.80	0.88	-9.1%
8832	0.34	0.38	-10.5%	9157	3.39	3.88	-12.6%
8833	1.17	1.14	2.6%	9158	1.76	1.85	-4.9%
8838	0.37	0.45	* -17.8%	9159	1.10	1.18	-6.8%
8840	0.35	0.39	-10.3%	9160	1.29	1.37	-5.8%
8854	2.77	3.20	-13.4%	9178	2.67	3.08	-13.3%
8855	0.10	0.10	0.0%	9179	4.27	5.28	-19.1%
8857	1.60	1.82	-12.1%	9180	1.77	2.33	-24.0%
8864	2.29	2.59	-11.6%	9182	1.72	1.87	-8.0%
8865	2.20	2.53	-13.0%	9186	2.77	3.65	-24.1%
8866	2.05	2.25	-8.9%	9220	6.78	6.59	2.9%
8868	0.34	0.34	0.0%	9402	3.66	4.24	-13.7%
8869	0.63	0.67	-6.0%	9403	7.98	8.78	-9.1%
8871	0.07	0.08	-12.5%	9410	5.61	6.01	-6.7%
8901	0.21	0.20	5.0%	9501	1.62	1.73	-6.4%
9014	3.30	3.69	-10.6%	9505	2.71	2.91	-6.9%
9015	1.22	1.47	-17.0%	9519	2.93	3.39	-13.6%
9016	3.33	3.41	-2.3%	9521	2.87	3.14	-8.6%
9019	1.42	1.87	-24.1%	9522	1.47	1.51	-2.6%
9025	11.64	12.95	-10.1%	9526	7.22	8.92	-19.1%
9026	3.32	3.48	-4.6%	9527	27.62	25.79	7.1%
9027	17.88	17.38	2.9%	9534	7.87	8.94	-12.0%
9028	2.45	2.78	-11.9%	9539	7.89	7.66	3.0%
9029	3.07	3.44	-10.8%	9545	6.62	8.59	-22.9%
9030	4.07	4.31	-5.6%	9549	2.64	2.78	-5.0%
9040	3.50	4.02	-12.9%	9552	7.45	8.04	-7.3%
9044	2.33	2.57	-9.3%	9553	3.23	3.78	-14.6%
9048	2.17	2.23	-2.7%	9585	0.45	0.57	-21.1%
9051	1.42	1.86	-23.7%	9586	0.47	0.53	-11.3%
9052	2.81	2.98	-5.7%	9600	2.56	2.67	-4.1%
9055	0.59	0.72	-18.1%	9610	0.91	0.86	5.8%
9058	3.23	3.95	-18.2%	9620	1.06	1.27	-16.5%

* Class Codes 8803 and 8838 have been broadened to include “clerical office employees” effective 10/1/2024. Please refer to R.C. Bulletin #2606 for further information.

** Class Code 8813 is a companion classification code for Class Code 4299 effective 10/1/2024. Its Loss Cost is based on Class Code 8810 until such time that Class Code 8813 develops its own experience. Please refer to R.C. Bulletin #2606 for further information.

IMPORTANT NOTICE – PAYOR COMPLIANCE PROGRAM – NEW YORK

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

In April 2015, the New York State Workers' Compensation Board issued Subject No. 046-760 to all employers, employees, insurance carriers providing benefits under the Workers' Compensation Law, attorneys and licensed representatives appearing before the Board regarding the Board's Payor Compliance Program. The subject number states that all payors (including carriers, third-party administrators [TPAs], self-insureds, self-insured trusts/groups and governmental subdivisions) will receive a quarterly report, starting in January 2016, of their performance in each of the following areas:

- Timeliness of the First Report of Injury Filing;
- Timeliness and Reporting of Initial Payment of Compensation;
- Timeliness of Notice of Controversy Filing; and
- Percentage of Claims Controverted.

Your timely reporting of claims is CRITICAL to ensuring compliance with this program. As mandated by WCL 110(2) and NYCRR 300.22, you, as an employer, must report any injury meeting either of the following criteria:

- Injury which has caused, or will cause, a loss of time from regular duties of one day beyond the work shift in which the accident occurred.
- More than ordinary first aid treatment, defined as a single treatment and subsequent observation of minor cuts, scratches, burns, splinters and the like, which do not ordinarily require medical care.

YOU MUST IMMEDIATELY REPORT ALL INJURIES THAT MEET EITHER OF THESE TESTS TO TRAVELERS OR YOUR TRAVELERS AUTHORIZED THIRD - PARTY CLAIMS ADMINISTRATOR.

For more information please visit the Workers' Compensation Board's website, www.wcb.ny.gov, to obtain detailed educational materials, including webinars and other training regarding the Payor Compliance Program.

IMPORTANT NOTICE – SAFE PATIENT HANDLING PROGRAM AFFIDAVIT – NEW YORK

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

The New York Safe Patient Handling Act Program allows a 2.5% premium credit for New York health care facilities that comply with the requirements of New York State Public Health Law Section 2997-k(2). If you are an employer that wishes to apply for this premium credit, please complete and sign the attached affidavit W31N4J17 and mail it to your Travelers representative. We will require an updated affidavit at each subsequent renewal. If we do not receive the executed affidavit within thirty (30) days of the policy's inception date no credit will be allowed for that policy period.

NEW YORK SAFE PATIENT HANDLING ACT
AFFIDAVIT OF COMPLIANCE

AFFIDAVIT OF: _____ *(name of health care facility)*

STATE OF: New York

COUNTY OF: _____

I _____ [NAME OF AFFIANT], being duly sworn, hereby attest to the following:

1. I am over the age of 18, and I reside in the State of _____ ;
2. I have personal knowledge of the facts stated herein, and, if called upon as a witness, will testify completely thereto;
3. I suffer no legal disabilities;
4. On or before _____ POLICY EFFECTIVE DATE], _____ [NAME OF HEALTH CARE FACILITY] (the "Facility") established a safe patient handling program;
5. The Facility has implemented a safe patient handling program;
6. The Facility conducts patient handling hazard assessments;
7. The Facility has developed a process to identify the appropriate use of the safe patient handling policy;
8. The Facility provides initial and on-going yearly training and education on safe patient handling for all employees involved in patient handling or movement;
9. The Facility has established procedures to ensure that retraining for any employee found deficient is provided as needed;
10. The Facility has set up and utilizes a process for incident investigation and post-investigation review, which may include a plan of correction and implementation of controls;
11. The Facility conducts annual performance evaluations of the program to determine its effectiveness;
12. The Facility considers the feasibility of incorporating patient handling equipment or the physical space and construction design needed to incorporate that equipment at a later date when developing architectural plans for constructing or remodeling a health care facility;
13. The Facility has developed a process by which an employee may refuse to perform or be involved in patient handling or movement that the employee reasonably believes in good faith will expose a patient or the employee to an unacceptable risk of injury.

I declare that the information stated herein is true, correct, and complete, to the best of my knowledge, information and belief.

Executed this _____ day of _____, 20____.

Signature

Printed name

Title

NOTARY ACKNOWLEDGEMENT

STATE OF _____, COUNTY OF _____,

_____

Notary Public

_____

My commission expires

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 2019, defines an act of terrorism 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 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 act of terrorism is *****, and does not include any charges for the portion of losses covered by the United States government under the Act.

*****SEE INFORMATION PAGE SCHEDULE FOR PREMIUM CHARGE

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-1T152983-25-14-G

NOTICE OF ELECTION TO ACCEPT THE OREGON EMPLOYER PAID MEDICAL CLAIMS

This notice applies only to medical benefits provided by Part One (Workers Compensation Insurance) because Oregon is shown in Item 3.A. of the Information Page.

1. Oregon law allows you to reimburse us up to a defined amount for medical services we have paid for any accepted nondisabling claim if you so choose. This defined amount is determined by the Workers' Compensation Division, Department of Consumer and Business Services, and is subject to an annual adjustment ('maximum reimbursable amount'), published annually by the Oregon Department of Consumer and Business Services in Bulletin No. 345.
2. The current maximum reimbursable amount is $2,500 per claim, but you can choose an amount lower than the maximum.
3. A nondisabling claim is defined as one where the injured person does not receive any lost time benefits.
4. If you choose to reimburse us for these medical payments made under this policy, you must still report the injury to us in the same manner that other injuries are reported but the amount paid by you will not be used in your subsequent experience rating modifications or otherwise be used to make charges against you. **Note that this reimbursement has no advantage unless your premium at least meets the experience rating threshold.**
5. If you choose to reimburse us for these medical payments made under this policy: (1) Complete the form below within thirty days of receipt of this notice; (2) Retain a copy for your records; and (3) Send a copy to us and your producer to inform him/her of your intention. An endorsement will then be attached to your policy to reflect your election.
6. Your election to participate in this program means that you agree to receive a monthly bill for the payments we made on your accepted nondisabling claims which are eligible for reimbursement. Please return a copy of your billing statement and payment within thirty days of receipt of the bill. Your failure to reimburse us will be deemed notice to us that you have decided to not participate in this program for that billing period. Notwithstanding, you will continue to receive monthly billing on any claim eligible for reimbursement for up to twenty-seven months of the inception of the policy period.
7. The bill may use the term 'deductible' in reference to the Oregon Employer Paid Medical Claims program billing.
8. **If you decide that you do not want to participate in the Oregon Employer Paid Medical Claims program, you may simply disregard this notice.** You are deemed to have chosen not to participate in this program if you fail to complete this notice and return it within thirty days of your receipt. Your policy will continue in force as issued. You may send this form in any time during the policy period if you change your mind going forward.

DATE OF ISSUE: 01-08-25 ST ASSIGN:

9. A new notice of election to accept the Oregon Employer Paid Medical Claims program will be provided to you on an annual basis for applicable renewal policies.

Yes, I wish to reimburse medical payments made on nondisabling claims as indicated below. Per claim reimbursement amount (choose one):

☐ $200; ☐ $300; ☐ $400; ☐ $500; ☐ $600; ☐ $700; ☐ $800; ☐ $900; ☐ $1000;
☐ $1100; ☐ $1200; ☐ $1300; ☐ $1400; ☐ $1500; ☐ $1600; ☐ $1700; ☐ $1800; ☐ $1900;
☐ $2000; ☐ $2100; ☐ $2200; ☐ $2300; ☐ $2400; ☐ $2500

Date: _____ Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

NOTICE TO OREGON WORKERS COMPENSATION INSURANCE POLICYHOLDERS

DO YOU LEASE ANY OF YOUR EMPLOYEES?

If you do, you must take immediate action. The 1993 Legislature passed a comprehensive law (HB 2282) regulating the employee leasing industry. Under the new law, leasing companies must be registered and pay workers compensation insurance premiums using their clients' experience ratings. The new law also requires that as long as you maintain your own workers compensation policy you must report the payroll for all workers you employ, whether leased or direct, to your insurer. You may continue to lease workers, but it is you responsibility to provide coverage and reports for workers compensation payroll and premium purposes while your policy is in place, since your insurer is responsible for their injury claims. If you wish to lease all of your workers, and leave full responsibility with the leasing company for providing workers compensation coverage, you must cancel your current policy by giving written notice to your insurance carrier.

Again, action must be taken if you lease employees. A copy of the recently adopted state Workers Compensation Division administrative rules is available upon request. If you have any questions regarding this law or the rules, please contact your agent.

STATE OF OREGON
IMPORTANT LOSS CONTROL INFORMATION

Your Rights And Responsibilities:

As an employer you are required by the Oregon Safe Employment Act (ORS 654.001 to 654.295 and 654.991) to provide a safe and healthful workplace. Refer to the enclosed Safety Services notice for available services offered to you.

Oregon OSHA Division 1 General Administrative Rules require that you, the employer, distribute this notice and the enclosed Safety Services notice to each of your fixed places of employment within the State of Oregon. We suggest you direct the information to the person assigned the responsibility for accident prevention.

If we fail to respond to a request for loss prevention services or otherwise fail to provide services as offered or required, you have the right to make a complaint to the OR-OSHA Division.

Notification of Services

The Oregon Administrative Rules require each insurer to inform insured employers of the loss prevention services that are available. The Rules also require that insured employers are notified of the following information.

Loss prevention services and personnel providing the services must meet the needs of the particular place of employment, special industry, or process, and shall include at least the following:

- **An on-site evaluation of the employers' loss prevention needs;**
- **Assistance in evaluating records that may be pertinent to the firm's illness and injury experience;**
- **An explanation to the employer of the Oregon Safe Employment Act and rules that apply to the particular place of employment;**
- **Provision of partial or complete on-site health and safety surveys, which identify all reasonably discoverable occupational safety and health hazards within the scope of the survey scheduled;**
- **Assistance with industrial hygiene and safety evaluations to detect physical and chemical hazards of the workplace, and implementation of engineering or administrative controls;**
- **Assistance with evaluating, obtaining, and maintaining personal protective equipment;**
- **Evaluation of work practices, workplace design, and assistance with job site modifications;**
- **Assistance in evaluating and improving an employers' safety management practices;**
- **Assistance in identifying health and safety training needs and available resources; and**
- **An offer to provide follow-up services.**

Our Risk Control Division offers these services at no additional charge upon request, when the nature of the operations and hazards warrant these services. To request loss prevention services see the enclosed Safety Services notice for the phone number of the Risk Control office nearest you.

POLICY NUMBER: **UB-1T152983-25-14-G**

AN INTRODUCTION TO WORKERS COMPENSATION

INTRODUCTION

In accordance with the intent of the Oregon law, this booklet was prepared for voluntary distribution to Oregon employers by the insurance industry. In it, you will find answers to basic questions about workers compensation insurance.

NATIONAL COUNCIL ON COMPENSATION INSURANCE (NCCI)

The National Council on Compensation Insurance is a voluntary, non-profit, statistical, research and ratemaking organization licensed under Oregon Revised Statutes 737.350. Supported by the insurance industry, NCCI's primary functions are the preparation and administration of rates, rating plans, and systems for workers compensation insurance. In Oregon, the NCCI prepares a schedule of rates for insureds in the assigned risk plan, subject to insurance department approval, and acts in an advisory capacity for insurers writing the rest of the business in the state.

As the rating organization, it is NCCI's obligation to collect payroll and loss information, by individual classification, for each workers compensation insurance policy in the state of Oregon. In addition, the rating organization will perform inspections at employers' premises to determine the proper classifications, perform test audits, promulgate experience rating modifications, and administer the Workers Compensation Insurance Plan (WCIP) for those employers unable to obtain coverage voluntarily.

WORKERS COMPENSATION RATES

NCCI uses the collected payroll and loss data to actuarially determine that portion of each individual classification rate necessary to pay the losses. This amount is called the pure premium. Oregon insurers may use the pure premiums determined by NCCI or their own when preparing their rates. Each carrier applies its own 'factor' to provide for the additional costs for taxes, licenses, fees, acquisition and field supervision, and other company expenses. This 'factored' rate is the amount charged per $100 of payroll.

CLASSIFICATIONS:

There are approximately 500 different workers compensation classifications, each of which individually describes a particular occupation.

Generally each employer will be entitled to the ONE basic classification which most accurately describes its operations. In addition, when that one basic classification does not specifically include one of the "Standard Exception" classifications (Clerical, Outside Salespersons, or Drivers), each employer may also be entitled to three additional classifications: Code 7380 - Drivers, Chauffeurs & Helpers; Code 8742 - Salespersons, Collectors or Messengers - Outside; and Code 8810 - Clerical Office Employees. Your insurance carrier will advise you of the classifications applicable to your operations.

However, when an employer is engaged in Construction, Erection, Stevedoring, Aircraft Operations (Industrial Aid), or Trucking as a secondary business, additional classifications may be assigned. Again, your carrier will counsel you on the classifications applicable to your operations.

DIVISION OF INDIVIDUAL EMPLOYEE'S PAYROLL

When any employee performs different duties which, if performed by a different worker, would qualify for a different classification assignment, you may divide that persons payroll between two or more classifications, PROVIDED separate verifiable payroll records are adequately maintained. When verifiable payroll records are not maintained, that individual's payroll must be assigned to the highest rated classification for any of the duties performed.

DATE OF ISSUE: **01-08-25**

VERIFIABLE RECORDS

Verifiable records are documents completed by an employee or supervisor every time the employee changes duties. These records should display the starting time and ending time for each type of work. Each block of time should note the duties the employee performed during that particular time period. Estimates or percentages of time spent in the different duties are not acceptable as verifiable records.

REMUNERATION - PAYROLL

"Payroll" means the TOTAL remuneration paid or payable by the employer for the services of the employees covered by the policy. Payroll INCLUDES commissions, anticipated bonuses, straight hourly wage for all hours worked, holiday pay, sick pay, piecework pay, tool allowances, value of living quarters provided by the employer, value of meals provided, value of store certificates or merchandise provided, and credits or any other substitute for money received by employees. Payroll does NOT INCLUDE profit-sharing amounts, unanticipated bonuses, vacation pay, tips or other gratuities received by employees from others, payments by the employer to group insurance or group pension plans, value of special rewards for individual invention or discovery, the value of a company-provided vehicle which is used in the employer's business or dismissal or severance payments except for the pay earned for the time worked. It also excludes payments from a program to reward workers for safe working practices.

SUBCONTRACTORS

When you subcontract a portion (or all) of your work to others and retain the right to exercise any direction and control (regardless of whether that right is exercised), you will be expected to pay the premiums for that subcontracted payroll UNLESS the subcontractor has its own workers compensation insurance coverage. In order to avoid the payment of premium for your subcontractors, you should obtain a CERTIFICATE OF INSURANCE from each subcontractor. At the time of audit, your insurance carrier will ask for any certificates of insurance and will exclude the subcontractor's payroll when the certificate is available.

EXPERIENCE RATING

When an employer's initial policy develops annual premium in excess of $5,000, the employer will qualify for experience rating at the beginning of the THIRD year and annually thereafter. When the employer develops premium in excess of $2,500 (but less than $5,000), they will qualify for an experience rating modification at the beginning of the FOURTH year. However, major changes in ownership may affect the continuation of individual employer data which may be used for experience rating purposes.

Essentially, the Experience Rating Program will use your company’s payroll, by individual classification, to determine the AVERAGE amount of losses expected to emerge from that payroll. It will then compare those EXPECT LOSSES to the ACTUAL LOSSES which were paid and/or reserved for any injuries occurring during the period covered by the data used in the annual experience rating process. When your company has BETTER than average experience, the experience modification will result in a CREDIT (reduction in our final premium), but if your experience is WORSE than average, a DEBIT (surcharge) will apply.

MERIT RATING

When an employer is too small to qualify for experience rating, a MERIT RATING program will apply. In general, this program will: a) reduce your final premium if there were no payments for "lost-time" injuries during the most recent year for which data has been compiled; b) will not affect your premium when there was only ONE lost-time injury; and c) will surcharge your premium when there are two or more lost-time injuries. Oregon law provided that, with the approval of regulatory authorities, insurance carriers may use their own customized merit rating plan. Maximum credits or surcharges are 10 percent. Check with your insurance carrier or agent for specific information about merit rating plans in effect in Oregon.

FEDERAL COVERAGES

While most employees will be subject to only the Oregon Workers Compensation Act, others MAY be subject to the Admiralty Act (for Masters or Members of a Vessel), to the Federal Employers Liability Act (Railroads engaged in Interstate Commerce), or the Longshore and Harborworkers Compensation Act (for stevedoring operations, building or repairing of vessels, new construction work in connection with marinas, etc.). However, the determination of exposures under any of the Federal Acts is a legal question which should be discussed with your insurance carrier or agent.

FINAL PREMIUM

When you obtain a policy from your insurance carrier, the premium will be ESTIMATED from the description of work and payroll information supplied by you. Your insurance carrier may either make interim audits or audit your account when your policy has expired. At that time, your final premium will be based upon the ACTUAL payrolls.

OREGON CLASSIFICATION AND RATING COMMITTEE

A Committee, composed of members well-versed in workers compensation insurance matters, meets periodically to hear the grievances of employers who feel they have been treated improperly in the assignment of classifications, payroll assignments, or experience ratings. (Since the 'rate' is an actuarial product which has been reviewed by the Insurance Department prior to approval for use, the appeal may NOT be based upon the rate or an individual classification. Should you feel you have been aggrieved, you may direct your specific allegations to the NCCI -Northwestern Service Office, One S.W. Columbia Blvd. (Suite 850) Portland, OR 97258 or contact your carrier for further information.

CONCLUSION

The above information has been designed to provide you with a broad overview of the Oregon Workers Compensation Insurance system. Should you have further questions, please contact your carrier or the NCCI Northwestern Service Office at the address indicated above.

IMPORTANT NOTICE TO OREGON POLICYHOLDERS

OREGON INSURANCE GUARANTY ASSOCIATION SURCHARGE

Most insurers doing business in Oregon participate in the Oregon Insurance Guaranty Association. In the event an insurer fails, the Association settles unpaid claims on behalf of consumers. Oregon law requires that policies be surcharged directly to recover the costs of handling those claims.

If your policy is surcharged, the term "OIGA Surcharge" along with an indicated dollar amount will be displayed with the statement of your surcharge.

NOTICE

RHODE ISLAND EMPLOYERS WHO USE TEMPORARY OR LEASED WORKERS

The Rhode Island Workers' Compensation Act ("Act") provides that in situations involving temporary or leased employees, the general employer, and not the special employer, is considered the employer for most purposes under that Act. When a workers is provided by a temporary employment agency or employee leasing company, that company is the general employer, and the company to which the employee is provided is the special employer. In the event of injury, a temporary or leased employee may proceed only against the general employer (the temporary employment or employee leasing agency) for benefits under the Act. Further, for the purposes of payroll and premium audit, the client company (you, if you use temporary or leased workers) is **not** considered the employer.

Effective January 1, 2006, client companies are required to obtain a valid "Rhode Island Workers' Compensation Insurance Coverage Certification" (DWC-09), from the temporary employment agency or employee leasing company used. The certificate of insurance is produced by the agency's insurance carrier and will confirm that coverage is currently in effect.

Additionally, should the agency's policy be cancelled or non-renewed the insurance carrier is required to notify the certificate holder and the Insurance Department in writing. **If you use temp or ary employees, and you do not secure the above certificate or do not take action when you receive written notice of cancellation or non-renewal, the law states that you will be deemed to be the employer as it relates to workers' compensation and be responsible for premium and losses relative to any of the temporary or leased workers.**

APPLICATION FOR DRUG-AND ALCOHOL-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

This form must be completed by you and returned to your carrier with a copy of applicable documentation as proof of compliance before the premium credit of 5% can be established and processed. *A program must be certified during each year the employer receives credit*. Failure to do so will remove you from eligibility for this credit.

Following are the four minimum requirements necessary for a qualified employer workplace program. Please check the items below that apply.

☐ **1. Substance Abuse Policy Statement:**

By law, any policy must be designed to help employees who need substance abuse assistance while, at the same time, sending a clear message that the abuse of drugs and alcohol is not compatible with employment in that employer's workplace. The policy statement must evidence both the employer's respect for its employees and the employer's need to maintain a safe, productive, substance abuse-free environment.

☐ **2. Employee Notification:**

In order to protect the individual rights of each employee and to begin the employee education process necessary for a well-defined, well-managed workplace drug and alcohol abuse prevention program, each existing employee and each new employee hired after program implementation must be given a clear, concise, readable notice of the program, the program's requirements, the policy statement, and the employer's expectations under the program. Notification should be, and should remain, posted in employee common areas. In addition, each existing employee and each new employee must be given, by mail or by in-person delivery, a copy of the notice. Delivery may be accomplished by inclusion of the notice within the employee's paycheck package or any similarly important-to-the-employee correspondence or benefits delivery.

☐ **3. Testing Procedure:**

The testing procedure must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer. If a second test is administered, the testing procedure may allow for a single sample to be split for use in the first and second tests. Positive test results must be provided in writing to the employee within 24 hours of the time the employer receives the test results. Each employer must keep records of each test for up to one year.

☐ **4. Test Results Confidentiality Protocols:**

Test results, information, interviews, reports, statements, and memorandums received by the employer must be considered confidential but may be used or received in evidence, obtained in discovery, or disclosed in any civil or administrative proceeding. The burden to protect against unauthorized release is placed not only upon the employer and any laboratory, medical review officer, or rehabilitation program or their agents, but also upon the underwriting carrier. Employers, laboratories, medical review officers, carriers, drug or alcohol rehabilitation programs, and employer drug prevention programs, and their agents who receive or have access to information concerning test results, must keep all information confidential. Release of such information under any other circumstance shall be solely pursuant to a written consent form signed voluntarily by the employee tested or their designee unless the release is completed through disclosure by an agency of the State in a civil or administrative proceeding, an order of a court of competent jurisdiction, or the determination of a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain, at a minimum:

(1) The name of the person who is authorized to obtain the information;
(2) The purpose of the disclosure;
(3) The precise information to be disclosed;
(4) The duration of the consent; and
(5) The signature of a person authorizing release of the information.

Information on test results shall not be released for or used or admissible in any criminal proceeding against the employee.

I certify that the above information is accurate.If it is determined that there is any misrepresentation of the established drug- and alcohol-free workplace premium credit program requirements, I may be subject to an additional premium charge. This is a true and factual depiction of my current program.

Employer Name	Date	Signature[1]
		Title
Notary Public's Signature	Date	Exp. of Commission

[1] Application must be signed by an officer, partner, sole proprietor, LLC member, or owner.

IMPORTANT NOTICE – INSURED'S RIGHTS
WORKERS' COMPENSATION PREMIUM DISPUTES – TENNESSEE

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

If you are insured under a workers' compensation insurance policy and have a dispute regarding the manual rules, classification, or rating plans, you must make a reasonable attempt to resolve this dispute with us. You must make your request to us in writing. We will conduct our review and communicate our decision to you in writing within thirty (30) days. If we fail to respond within forty-five (45) days or if you are dissatisfied with the results, you may contact National Council on Compensation Insurance, Inc. (NCCI) requesting a review through the Dispute Resolution Process (Process).

According to NCCI's procedures:

a. Initial requests for dispute resolution services must be sent to NCCI at one of the following:

Mail:
NCCI
Dispute Resolution Services
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

Email: disputeresolution@ncci.com

Fax: 561-893-5043

b. The dispute resolution request sent to NCCI must also be sent simultaneously to all other parties to the dispute.

This written request for review must contain the following:

a. Your name, address, daytime telephone number, and (if you have one), the Federal Employer Identification Number (FEIN);
b. An explanation of what is being disputed;
c. A statement of the relief sought;
d. A statement that you have attempted to resolve the dispute directly with us, but have not been able to do so;
e. A statement that you have furnished a copy of the request for review to us with which you have a dispute;
f. A statement of how you wish to appear before the Panel (by mail, by telephone, or by video conference);
g. Your signature as the policyholder; and
h. A legible copy of any relevant policy of insurance, workers compensation experience rating worksheet, or audit information and any other correspondence that you have received from us with regard to the matters in dispute.

Within 15 business days of receipt by NCCI of a request for review, NCCI will grant or deny the request and if granted, NCCI will promptly give written notice to all parties of the date, time, and manner in which the Panel will consider the dispute; otherwise, NCCI will give written notice to you and us that the request for review is not granted and will state the reasons the request is not granted, and will state the deadline for filing an amended request for review, if applicable.

You must file a request for review with NCCI within three years of the expiration date of the policy in question. Any extension of time to file a request for review will be granted at the sole discretion of NCCI.

The NCCI Panel:

1. Will not have the authority to interpret, apply or opine on state or federal laws, rules, or regulations, or decisions of courts or administrative proceedings; or to hear disputes brought by carriers.
2. A request for review will be denied if it fails to state an issue that is within their authority or has been untimely submitted.
3. A request for review may be denied if you fail to provide adequate information for NCCI to evaluate the merits of the dispute. In this case, NCCI will notify you and us in writing. You will be allowed to amend the request for one time only otherwise a denial will be final if an amendment is not received within 10 days.

If you wish to appeal the decision made by the Panel to the Tennessee Commissioner of Insurance send a written request for appeal to:

State of Tennessee
Department of Commerce and Insurance
Actuarial Services Section
500 James Robertson Parkway, 4th Floor
Nashville, Tennessee 37243-0574

A request for an appeal must be made within 30 days after the date of the issuance of the Panel's decision or the decision of the Panel will become final and the parties will have waived their right for further review by the Tennessee Department of Commerce and Insurance.

IMPORTANT NOTICE – TENNESSEE
PROOF OF WORKERS' COMPENSATION INSURANCE COVERAGE

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

If you are in the construction services business, Tennessee workers' compensation statute Title 50, Chapter 6, Section 10: 50-6-901 require that you provide proof of valid workers' compensation insurance coverage at your place of business and at job sites where you are providing construction services.

To assist you with providing proof of workers' compensation coverage, your coverage information is available to download at these websites:

https://www.ewccv.com/cvs/?ref=https%3A%2F%2Fwww.google.com%2Furl

http://www.dlt.ri.gov/wc/pdfs/mobileappinstructions.pdf

Please be informed of the potential for a penalty of not less than fifty dollars ($50) nor more than five hundred dollars ($500) per violation if you fail to provide proof of valid workers' compensation insurance coverage within one (1) business day at your place of business or job sites where you are providing construction services. Subsequent violations may result in a penalty of not less than fifty dollars ($50) nor more than five thousand dollars ($5,000). The amount of the penalty is at the discretion of the administrator or administrator's designee.

Have a workers' compensation complaint or need help?

Contact your insurance company, if you have a question or problem about your premium or a claim:

Travelers

Call: Consumer Affairs at 1-860-954-2382

Toll-free: 1-866-894-0687

Online: www.Travelers.com

Email: COMPLAINTS@travelers.com

Mail: Attn: Consumer Affairs, One Tower Square, Hartford, CT 06183

For problems with your policy

If your problem with the premium is not resolved, contact the National Council on Compensation Insurance, Dispute Resolution Services:

Mail: 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362

Fax: 561-893-5043

Email: disputeresolution@ncci.com

Phone: 1-800-622-4123

If you believe there has been a violation of law related to your workers' compensation policy, file a complaint with the Texas Department of Insurance:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030

For employees with claim issues

If one of your employees has a problem with a claim, contact the Texas Department of Insurance, Division of Workers' Compensation, Compliance and Investigations:

Mail: Compliance and Investigations, MC: CI, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 12050, Austin, TX 78711-2050

Fax: 512-490-1030

Email: DWCCOMPLAINTS@tdi.texas.gov

Phone: 1-800-252-7031

¿Tiene una queja de compensación para trabajadores o necesita ayuda?

Comuníquese con su compañía de seguros si tiene una pregunta o problema relacionado con su prima de seguro o con una reclamación:

Travelers

Llame a: Consumer Affairs al 1-860-954-2382

Teléfono gratuito: 1-866-894-0687

En Línea: www.Travelers.com

Correo electrónico: COMPLAINTS@travelers.com

Dirección postal: Attn: Consumer Affairs, One Tower Square, Hartford, CT 06183

Para problemas con su póliza:

Si su problema con la prima de seguro no es resuelto, comuníquese con el Consejo Nacional de Seguros de Compensación (National Council on Compensation Insurance, por su nombre en inglés). Servicios para la Resolución de Disputas:

Correo postal: 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362

Fax: 561-893-5043

Correo electrónico: disputeresolution@ncci.com

Teléfono: 1-800-622-4123

Si usted piensa que ha habido una violación a la ley, la cual está relacionada con su póliza de compensación para trabajadores, presente una queja ante el Departamento de Seguros de Texas:

Llame al: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Correo postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030

Para empleados que tienen problemas con sus reclamaciones

Si uno de sus empleados tiene un problema con una reclamación, comuníquese con la Sección de Cumplimiento e Investigaciones (Compliance and Investigations, por su nombre en inglés) del Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation, por su nombre en inglés).

Correo postal: Compliance and Investigations, MC: CI, Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 12050, Austin, Texas 78711-2050

Fax: 512-490-1030

Correo electrónico: DWCCOMPLAINTS@tdi.texas.gov

Teléfono: 1-800-252-7031

West Virginia
Workers Compensation
Managed Health Care Plan

Inside:

- Employer Information
- Employee Handbook
- Employee Rights and Responsibilities
- Employee Grievance Form
- Employee Satisfaction Survey

Employee Handbook including the Important Information for Employees, Rights and Responsibilities, Grievance form and Identification Card are to be shared with each employee at time of injury. The other informative materials can be used at your discretion.

W47N1I20

Dear Employer:

Thank you for taking an active role in helping manage your workers compensation exposures. The enclosed kit of information is designed to give you basic knowledge of your Workers Compensation Managed Health Care Plan ("MHCP"). The West Virginia Offices of the Insurance Commissioner has approved the Travelers Managed Health Care Plan.

The MHCP encourages you to ensure that your Employee's choose a treating doctor participating in the MHCP. By taking an active role in ensuring the use of the MHCP, you may be able to expedite medical recovery for your injured employees and reduce lost time days.

The enclosed materials will help you make effective use of the MCHP. The Network Directory is an important part of this managed health care plan.

You should:

1. Determine the Treating Doctors or occupational clinics available near your work-site by reviewing the Directory.
2. Doing so in advance will make it quick and easy to assist in finding appropriate medical care for the Employee should a work-site injury occur.
3. Direct the Employee to choose a treating doctor from the Directory when a work-related injury occurs.
4. Complete a copy of the Request for Medical Treatment form enclosed in this kit and give it to the injured Employee to take with him/her to the treating provider.
5. Please provide a copy of the Employee Handbook listed below, to all employees at the time of their injury.

Providers within the Network are experienced in Workers Compensation and have contractually agreed to comply with West Virginia Workers Compensation Law. It is in everyone's best interest to return your Employee to work as soon as it is medically appropriate. The availability of modified and/or transitional duty programs at the work-site is key to this approach.

We have enclosed the following materials for your use:

1. What To Do When An Employee Reports An Injury
2. How To Find And Use The Network Directory
3. Request For Medical Treatment Form
4. Employee Handbook
    * Important Information for Employees
    * Grievance Form
    * Employee ID Card
5. Employee Satisfaction Survey

If you have any questions on the enclosed materials, please do not hesitate to call me at 1-866-336-8222. Your active role can mean better control of your Workers Compensation costs.

Sincerely,

Managed Health Care Plan Administrator

Enclosures

W47N1I20

What To Do When An Employee Reports An Injury

When emergency medical attention is required, send the injured employee to the nearest medical facility and contact the telephone reporting center at 1-800-832-7839 for national accounts, and 1-800-238-6225 for commercial, construction, and select accounts.

When an employee reports an injury not requiring emergency treatment, the following steps should be observed:

1. GATHER INFORMATION REGARDING THE INJURY

Ask the injured employee how, when and where the injury occurred, and if there were any witnesses.

2. CONTACT TELEPHONE REPORTING CENTER TO REPORT THE CLAIM

Upon direction from the Claim Adjuster, send the injured employee for medical treatment. Remember: If this is a medical emergency, direct the employee to seek medical attention immediately and then follow-up with this call.

3. COMPLETE THE EMPLOYER'S REPORT OF INJURY OR EMPLOYER'S REPORT OF OCCUPATIONAL DISEASE.

It is important to complete and file paperwork as soon as possible. WV code 23-4-1b requires you to complete and submit the form within 5 days of receipt of the notification of the employee's injury.

4. PROVIDE NOTIFICATION DOCUMENTS TO EMPLOYEE

Upon notice of an injury, provide the employee Managed Health Care Plan Handbook and completed ID Card.

5. DIRECT THE INJURED EMPLOYEE TO CHOOSE A TREATING PHYSICIAN.

When emergency medical care is required – If your employee sustains a life-threatening injury or an injury that could cause further medical complications, dial 911, and have your employee transported to the nearest emergency medical center. Under the MHCP, the emergency medical facility does not have to be a Plan provider.

If your employee sustains an injury or disease that is not life threatening and does not pose the risk of causing further injury, direct your employee to a primary medical care facility. If a facility is not available within 75 driving miles of your physical location, the employee may be treated at a facility outside the network. You may find a list of facilities in your area at www.Travelers.com/injuredemployee or by contacting the MCHP at 1-866-336-8222.

6. COMPLETE AN EMPLOYEE INTRODUCTION LETTER

Fill in a copy of the Request For Medical Treatment Form with the appropriate information. Give the completed Request for Medical Treatment Form to the injured employee and advise him/her to give the letter to the provider he/she has chosen as his/her Treating Provider before treatment is initiated.

7. ARRANGE FOR THE EMPLOYEE TO BE TREATED BY A PROVIDER WITHIN THE NETWORK

Either you, the Medical Case Manager, or the Claim Adjuster should contact the Provider to advise that they are on their way or arrange an appointment for treatment of the injured employee.

8. FOLLOW-UP AND RETURN-TO-WORK

Work with the assigned Medical Case Manager, Claim Case Manager, and the Treating Provider to return the employee to either light or full duty. Evaluate any restrictions and offer modified duty if applicable.

W47N1I20

9. PHARMACY BENEFITS

If the employee requires pharmacy benefits, send them to the nearest Plan pharmacy along with the MHCP Identification card provided within this packet. Under the plan, regardless of the disposition of the claim, the employee is eligible for a guaranteed first fill of his/her pharmacy benefit with no out-of-pocket cost. In the event the claim is rejected, you will not be responsible for payment. In the event the employee pays for a prescription related to his or her industrial injury, submit the receipt along with the details of the prescription to case manager assigned to the claim.

10. QUESTIONS

If you have any questions relating to this MHCP, please contact the Plan at:

Writing:	Travelers P.O. Box 4614 Buffalo, NY 14240-4614 Attn: Managed Care Plan Admin.
E-Mail:	WVMHCP@travelers.com
Calling toll-free:	1-866-336-8222

How to Find and Use the Network Directory

1. For those who have Internet access, use of the www.Travelers.com/injuredemployee web page can provide access to selection of network providers. Otherwise please contact the MHCP for a provider directory.

2. Review the list of providers in the area to determine the nearby treating providers or occupational clinics. Doing so in advance will enable you to be prepared in the event a work- site injury occurs.

3. Make sure your staff has access to the provider listings and explain to them how easy it is to use providers in the Network. Provider names, addresses, and telephone numbers are readily available with driving directions on the web site.

4. Advise the staff that use of the network providers is mandatory except in emergency situations. The providers participating in the Network meet specific quality standards and credentials and are experienced in treating work-related injuries and illnesses.

5. In non-emergency situations, complete the Request for Medical Treatment Form for the injured employee. Instruct the employee to bring the form with them to present to the treating provider. The Request for Medical Treatment form explains to the provider that the employee is a participant in a Managed Health Care Plan.

6. If you have any questions concerning the use of the Network, please call the Workers Compensation Managed Health Care Plan at 1-866-336-8222.

Workers Compensation Managed Health Care Plan
Request For Medical Treatment Form

Part 1: (To be completed by Supervisor. Please Print.)

Employee Name:_____ Social Security Number:_____

Date:_____ Supervisor Name:_____

Employer Name:_____ Supervisor Phone Number: _____

Employer Address:_____

Date of Injury:_____ Place of Injury:_____

Injury Description:_____

Part 2: (To be completed by Employee. Employee should take this form to the treating physician.)

I authorize payment directly to the provider for the medical services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designee for medical review.

Employee Signature:_____ Date:_____

***Note* By providing this form to the Employee, neither the Carrier/Claim Administrator nor the Employer concede compensability or eligibility of the injury described above under the applicable Workers Compensation laws.**

Part 3: (To be completed by treating physician. Please print.)

The physician should complete this information, give one copy to the Employee (to return to the Employer), attach one copy to your itemized bill and medical report to the Carrier/Claim Administrator, and keep third copy for your records.

I have treated_____ for_____ and found that he/she:
(Employee Name) (Medical Condition)

[ ] Is able to return to his/her present job

[ ] Can return to modified duty with the following restrictions:_____

[ ] Cannot return to work at the present time. Estimated period of disability:_____

[ ] Follow-up with me in_____ days or_____ weeks, and/or referral to:_____

[ ] Other comments:_____

Physician Name (Please Print):_____

Physician Signature:_____ Date:_____

W47N1I20

Part 4: (Important information for Medical Providers)

Pursuant to Title 85-21, the West Virginia Offices of the Insurance Commissioner established the requirement and procedures to be followed by the Commission, parties to claims before the Commission, employers, and managed health care plan administrators and others involved in the delivery or proposed delivery of managed care to the injured worker pursuant to W. Va. Code §23-4-3(b)(2).

The goal of Managed Health Care Plans is to assist workers to return to work as soon as practicable after a compensable injury and to otherwise provide for high quality, cost effective medical care to the injured worker. The following information being provided to you is to assist you as a medical provider to ensure compliance with the rules. This Employer is covered by a Managed Health Care Plan (MHCP) that has been approved by West Virginia Offices of the Insurance Commissioner.

The MHCP provides the following features:

1. A preferred provider network, which provides access to medical facilities and providers throughout the state. The network provides injured employees with a reasonable choice of providers, including adequate specialty and subspecialty providers, and general and specialty hospitals.
2. No co-payments or deductibles. All approved treatment will be paid under The Plan in accordance with West Virginia's state fee schedule and preferred provider rates. Injured employees will never have to pay a co-payment or deductible for approved treatment.
3. A claim adjuster and medical case manager to assist injured employees in obtaining proper medical care to help in their recovery and prompt return to work. They can be reached at **1-866-336-8222.**
4. Injured workers rights, responsibilities and confidentiality policies are provided to all injured workers and providers.
5. A pharmacy benefit program, which provides a network of pharmacies throughout the state and allows injured employees to obtain approved pharmaceuticals hassle-free, with no out-of-pocket expense.

Upon review by the MHCP, an employee may seek treatment outside network under the following conditions:

1. For emergency care when access to a health care provider within The Plan is unobtainable for the acute phase of care;
2. When authorized treatment is unavailable through The Plan;
3. To obtain a second opinion when a plan physician recommends surgery and another qualified physician within The Plan is not available for consultation; or
4. Establish by competent evidence that all of the following applies to their care:
    a. The employee has been treated by providers solely within The Plan for a period of at least one (1) year.
    b. For reasons related to the employee's treatment alone, he or she has not made progress toward recovery that is reasonably consistent with the Commission's treatment guidelines.
    c. The employee establishes, to a reasonable certainty, that proposed treatment outside The Plan would more likely provide him or her with a better clinical outcome than the current treatment or rehabilitation plan.

Part 5 (Claim Information)

1. Print the Employee's claim number or social security number and date of injury on any bills and reports. Bill only for services directly related to the injury listed above and submit itemized bill and medical report, along with a copy of this completed Request For Treatment Form, to the claim office.
2. Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both, imposed pursuant to applicable statutes and/or regulations.

Important Information for Employees
Regarding Medical Treatment for a Work-Related Injury or Illness

Travelers

Managed Health Care Plan for Workers Compensation

You are being provided this handbook because you have sustained an injury. Your employer's workers compensation related medical care is being provided through a Managed Health Care Plan ("MHCP"). This program has been approved by the West Virginia Office of the Insurance Commissioner.

This notice describes the program and your rights in choosing medical care for work- related injuries and illnesses. Receipt of this handbook does not construe acceptance of your claim.

If you want information about the MHCP, you can contact the Plan Administrator by:

Writing:	Travelers P.O. Box 4614 Buffalo, NY 14240-4614 Attn: Managed Care Plan Admin.
E-Mail:	WVMHCP@travelers.com
Calling toll-free:	1-866-336-8222

The Plan Administrator will:

- Answer your questions about the MHCP;
- Help you find the names of MHCP providers within your area;
- Help you get an appointment with a MHCP provider if you are having trouble.

What is a Health Care Network (MHCP)?

An MHCP is a program that helps manage medical care for work-related illnesses and injuries. The MHCP requires you to use specific hospitals and doctors if you incur a work-related illness or injury.

Each MHCP is required to have enough participating hospitals and doctors near your employer's facility. These hospitals and doctors specialize in work-related injuries.
MHCP providers must meet quality standards and provide care according to standard treatment guidelines.

Where is the MHCP certified to operate?

The MHCP is certified in all counties.

What happens if I am injured at work?

If you have a work-related injury or illness that is:

- An emergency; or if you need emergency care after normal business hours, call 911 or go to the nearest emergency room or urgent care center regardless of whether or not the provider is an MHCP provider. **Notify your employer as soon as possible after any emergency treatment.** Your claim will not cover any payment for care provided outside the MHCP that is determined not to be emergency care.
- Not an emergency, notify your employer right away. The treating provider you choose must be from within the MHCP. If you need after hours care for a non- emergency, you can get a list of MHCP hospitals and urgent care centers by calling the MCHP; or by accessing a list on the website at www.Travelers.com/injuredemployee.

What is an MHCP treating physician?

An MHCP treating physician is a doctor who will:

- treat you for your work-related injury or illness;
- coordinate all related care;
- refer you to any necessary specialist within the plan;
- participate in case management activities with the Plan; and
- provide maximum medical improvement and impairment ratings.

A treating physician can be a medical doctor, an osteopath, a podiatrist, or a chiropractor who has contracted to provide workers compensation treatment under the Plan.

How do I choose an MHCP treating physician?

You must choose a treating physician from the list of MHCP doctors that are within 75 driving miles of where you work.

If you need help in finding an MHCP provider, you can contact your Medical Case Manager ("MCM") or the MHCP Administrator at 1-866-336-8222 or log onto the website www.Travelers.com/injuredemployee. If you call the MHCP outside of normal business hours, you may leave a message and your call will be returned on the next business day. You can also ask your Employer for a copy of the MHCP provider list.

The list of MHCP providers is updated periodically. The provider list will provide you with the names and addresses of network providers grouped by specialty. All treating doctors are identified and listed separately from specialists.

MHCP contracted providers have agreed to look only to the MHCP for payment for the compensable medical care that they provide to you. You will not have to pay for medically necessary care you get from an MHCP provider related to your compensable work-related injury; nor will you be responsible for any deductibles or copays be required in order for you to receive care. However, if you receive medical care from providers who are not in the MHCP you may have to pay for that care.

What if I already have a workers compensation injury?

If you were injured at work before your employer participated in the MHCP you must choose a treating physician from within the network. All future care for your workers compensation injury must be provided by your new MHCP treating physician.

Can I change my MHCP treating physician?

If you want to change your treating physician, you must receive approval from the MHCP prior to receiving care by the new MHCP provider. You can call your MCM to request approval to change your treating physician.

You do not need approval to change your treating physician if:

- Care is transferred after an initial emergency or first aid treatment if done so within 30 days of the date of your injury;
- Your original treating physician transferred your care to a specialist; or
- You require care for an unforeseen emergency which requires special facilities and skills that are not available to your treating physician or hospital.

What if my treating physician says I need services from a specialist?

Except for emergency services, your treating physician will provide all treatment related to your workers compensation injury. If necessary, your treating physician may refer you to an MHCP specialist. If you need help getting an appointment with the specialist, call the MHCP for assistance at 1-866-336-8222.

What happens if my treating provider leaves the network?

- If your doctor decides to leave the network, you will be notified via telephone and in writing by the MHCP. You must then select another doctor from the Plan.
- If your treating doctor is terminated by the MHCP, you will be notified in via telephone and in writing by the MHCP. If this happens you will have to select an alternate MHCP treating physician right away.

Under what circumstances can I treat with a provider who is not in the plan?

You may receive treatment from a non-network doctor with approval from the MHCP if:

- Your treatment is an emergency;
- You need medical services not provided by the MHCP;
- You would like a second opinion for a surgery recommended by a Plan provider and another Plan provider is not available for consultation; or
- There is competent evidence that you have been treated in the Plan for one year and you have not made progress toward recovery, and the proposed treatment would provide better clinical outcomes.

If any of these situations apply to you, call the MHCP at 1-866-336-8222 to request approval for non-network care.

Unless it is an emergency you should not obtain medical services outside of the MHCP without approval.

The MHCP will make a decision related to your request within 10 working days. If your request is denied you will be sent notice of the network requirements and you must choose a treating physician from the list provided to you. If you do not agree with the MHCP's decision, you may file a grievance in accordance with the MHCP Grievance Procedure.

While waiting for a decision to be made you must seek care from network providers. If you choose to receive medical care from outside the network, while you are waiting for a decision to be made, you may be required to pay for those health care services you received outside the Plan.

Services obtained outside the MHCP are for treatment purposes only. You must see a Plan provider to obtain an impairment rating.

What is the MHCP service area?

The MHCP provides access to primary treating providers or hospitals within 75 miles of your employer's facility; and access to specialists and specialty hospitals within a reasonable distance from the facility. If you think there are not enough providers or no appropriate providers within the mile range noted above for primary care or in a reasonable distance for all other care, contact the MHCP to request approval for non-network care and provide evidence to support your claim.

The MHCP will review your request and send you a written decision within 10 working days. While your request is being reviewed, you may choose to receive health care services from a non-network doctor. If you make this choice, you may be responsible for payment if it is found that there are appropriate providers within the MHCP service area. If it is found that there are appropriate providers within the service area and those providers are available to you, the MHCP will send you notice of the network requirements and you must choose a doctor from the list provided to you.

Do any medical services require pre-authorization?

Yes. Medical care requires authorization from the MHCP before it can be performed. Your doctor will request that the MHCP pre-authorize those services. The MHCP will review treatment requests from your treating doctor against standard treatment guidelines to determine the medical necessity of the requested treatment.

What happens if my treating doctor's request for care isn't approved?

If any of your proposed medical care is determined not to be medically necessary, you will be notified in writing. This decision is called an adverse determination. The adverse determination notice will include instructions for submission of an appeal to the Plan. You must complete the adverse determination process before filing a grievance.

You receive a notice following any request for appeal stating the outcome of that review. If that notice upholds the adverse determination it will include instructions on how to request a grievance.

How do I file a complaint/grievance?

You and your providers have the right to file a complaint or grievance with the MHCP. A complaint or grievance can be filed regarding services provided by the MHCP or its network providers, within 30 days of the event or occurrence that is the basis for the complaint/grievance. Complaints or grievances must be filed in writing on the attached form to:

Travelers
P.O. Box 4614
Buffalo, NY 14240-4614

Attn: MHCP Grievance Coordinator

The MHCP Grievance Coordinator will review and render a written determination regarding the complaint within 30 days of receipt. A physician will be consulted in the determination process if the grievance is medically-related.

Be sure to include the following information in your request: your name; current physical address; telephone number; name and address of your provider; a description of the event or occurrence that is the basis of the complaint and any other information you feel would be helpful in making the determination.

If you disagree with the MHCP's resolution of your complaint, you may appeal the decision to the Office of the Judges within 60 days. You will be notified of the decision, and any written determinations regarding your medical treatment.

West Virginia Workers Compensation Managed Health Care Plan

GRIEVANCE FORM

An Injured Worker or Health Care Provider should use this form to request a formal review regarding dissatisfaction with services, including medical care issues, provided by or on behalf of a Workers Compensation Managed Care Arrangement.

This Grievance is being filed by:

- ☐ Provider
- ☐ Family Member
- ☐ Injured Worker or a Designated Representative
- ☐ Attorney
- ☐ Other

Date of Injury: _____

INJURED WORKER'S / PROVIDER'S NAME: _____

Social Security Number: _____

Address: _____

Home Telephone: _____ Work / Alternate Phone: _____

Telephone number of the contact if other than injured worker or provider: _____

TREATING PHYSICIAN: _____

Address: _____

Office Telephone: _____

Please describe your concern below. If you require additional space, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem):

_____

_____

_____

_____

_____

_____

_____

Has a grievance been previously filed? ☐ YES ☐ NO. If YES, Date Sent? _____

What action would you like to see taken?

_____

_____

_____

_____

_____

W47N1I20

INTENT: The grievance procedure is intended to be self-executing and easy to use. Please complete this form and send it to the address shown below. A review regarding the grievance will begin immediately, and a decision made within 30 days of receipt.

The injured worker's participation in the grievance process is important to the resolution of the issues. Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer of carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Protest with the WV Office of Judges as set forth in the West Virginia Code.

Any person who, knowingly and with intent to injure, defraud or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by:

Injured Worker/Provider/Other	Date Form Completed/Signed
Signature of Grievance Coordinator	Date Grievance Coordinator Signed

MAIL TO:

Workers Compensation Managed Health Care Plan Travelers
ATTN: GRIEVANCE COORDINATOR
P.O. Box 4614
Buffalo, NY 14240-4614

W47N1I20

Employee ID CARD

Travelers
WV Managed Health Care Program
Employee ID Card

Employer: _____

Address: _____

Phone: _____

Employee Name: _____

Social Security No: _____

Date of Injury: _____

Claim Number: _____

Travelers
WV Managed Health Care Program
Employee ID Card

Contact the Plan at:
Travelers WV Managed Health Care Plan
P.O. Box 4614
Buffalo, NY 14240-4614
Phone: 1-866-336-8222
Fax: 1-800-896-9547

Email : WVMHCP@travelers.com

Pharmacy Network: Healthesystems (877-528-9497) BIN# 012874

Note: Possession of verification or an ID card is not authorization for medical services or payment.

W47N1I20

Workers Compensation Managed Health Care Plan

Employee Satisfaction Survey

The form on the following page is a feedback mechanism for expressing results of medical treatment.

This feedback form is used by Travelers in a random survey process to determine satisfaction with the providers in the Workers Compensation network.

You, as an employer, may want to use this form when an employee:

- Expresses satisfaction with care that was provided
- Dissatisfaction with care that was provided
- Concerns about the facility/office
- Positive experiences with the facility/office

When an employee is dissatisfied please encourage them to provide their address on the survey in case it is necessary to make contact for additional information.

Managed Health Care Plan

We want you to be satisfied with the medical treatment you have received as a participant in the Travelers Workers Compensation Managed Health Care Plan. We appreciate your input on the following:

_____

(Name of Provider/Clinic)

(Please circle appropriate choice)

1. Was the clinic or office clean?
   A. very clean
   B. somewhat clean
   C. dirty
   D. very dirty
2. How long did you wait to be seen by the medical staff?
   A. less than 20 min.
   B. 30-45 min.
   C. 45 min- 1 ½ hrs.
   D. over 1 ½ hrs.
3. Were you treated with care and attention?
   A. very much so
   B. careful and attentive
   C. not so careful or attentive
   D. very inattentive
4. Did the medical staff explain your diagnosis and/or treatment plan?
   A. very much so
   B. explained somewhat
   C. did not fully cover all issues
   D. did not explain at all
5. Overall, were you satisfied with your visit?
   A. very satisfied
   B. somewhat satisfied
   C. somewhat dissatisfied
   D. very dissatisfied

ADDITIONAL COMMENTS:_____

_____

NAME:_____ DATE:_____

ADDRESS:_____ PHONE NUMBER:_____

*****Please return this completed questionnaire via mail to:

Travelers

Attn: Managed Care Plan Administrator
P.O. Box 4614
Buffalo, NY 14240-4614

Or Fax to: 1-800-896-9547

W47N1I20

IMPORTANT NOTICE – COMPLAINTS – WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Travelers
Attn: Consumer Affairs
One Tower Square
Hartford, CT 06183
1-800-954-2382
www.Travelers.com

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE,** a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at www.oci.wi.gov, or by contacting:

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

IMPORTANT NOTICE TO EMPLOYERS

DO YOU NEED USL&HW COVERAGE?
DO YOU NEED OTHER FEDERAL COVERAGES?

REVISED WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

All employers should carefully review their workers compensation coverage needs with their Insurance professionals – your agent, broker, or insurer. The Workers Compensation and Employers Liability Policy does not provide federal coverages (such as United States Longshore and Harbor Workers' Compensation Act, Defense Base Act, Nonappropriated Fund lnstrumentalities Act, Outer Continental Shelf Lands Act, or Black Lung Act) unless federal coverages are added by endorsement. Your old policy would normally exclude such federal coverages by means of standard amendatory endorsements unless you had requested the coverage when applying for or renewing your policy. Now the exclusions are part of your standard policy. Please note: You may also have had separate Workers Compensation and Employers Liability Policies –one that covered your Alaska Workers Compensation Act exposures and one that covered your federal act exposures.

To secure a federal coverage under the Workers Compensation and Employers Liability Policy, you must specifically request the necessary federal coverages and then carefully review your policy when you receive it to make certain that an amendatory endorsement adds the federal coverage that you requested.

What if an employer is uncertain if it will need a federal act coverage during the policy term?

Many employers such as construction contractors or oil services contractors will not know what contracts they will get during the policy term at the time a policy is purchased. Such an employer may not know if a job will involve exposure to federal acts such as USL&HW and/or Alaska Workers Compensation Act exposures. Other employers may have employees whose work falls in gray areas where the employer cannot predict which jurisdiction will apply should the employee be injured on the job.

To avoid potential coverage gaps, these employers should have their polic y endorsed to provide the needed federal act coverages on an “if any” basis. The employer would have to maintain payroll and job records as required by their insurer to document whether the employee's payroll should be classified Alaska Workers Compensation Act or a federal act such as USL&HW so that premium may be properly calculated; the rates are generally different. If federal exposures develop during the policy term, the employer's premium will be adjusted to reflect the additional exposure.

However, an employer whose employees' work takes them in and out of federal and state act jurisdictions must have coverage for both exposures on an ongoing basis, not an "if any" basis.

IMPORTANT
Policy Audit Information

Dear Policyholder:

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

Record Maintenance

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

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

IMPORTANT COVERAGE NOTE:

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

Work in Other States

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

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

TRAVELERS

PRIVACY NOTICE

PRIVACY POLICY

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

Collection Of Information

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

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

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

Disclosure Of Information

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

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

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

Confidentiality And Security

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

Disclosure and Protection of Former Customers' Information

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

Changes In Privacy Policy

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

IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION

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

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

IMPORTANT NOTICE

TENNESSEE POLICYHOLDERS
UTILIZING SOLE PROPRIETOR OR PARTNERSHIP
SUBCONTRACTORS

Dear Policyholder:

If you utilize the services of sole proprietor or partnership subcontractors, it is very important that you read this notice.

In Tennessee, all persons engaged in the construction industry, including principal contractors, intermediate contractors or subcontractors are required to carry workers' compensation insurance for their employees, even if they employ fewer than five employees. However, sole proprietors, partners, officers of corporations, members of limited liability companies and owners of family owned businesses may file for an exemption from this requirement. A list of exempted providers is published on the Secretary of State's Workers' Compensation Exemption Registry found at https://tnbear.tn.gov/wc/.

The Tennessee Workers' Compensation Law sets forth seven factors to be considered in determining whether an individual is an employee or a subcontractor / independent contractor (T.C.A. Section 50-6-102(11). These are the factors which we will apply at time of audit to ultimately determine the employment status of your workers. Below are the seven factors dictated in the law:

- **a.** The right to control the conduct of the work;
- **b.** The right of termination;
- **c.** The method of payment;
- **d.** The freedom to select and hire helpers;
- **e.** The furnishing of tools and equipment;
- **f.** Self-scheduling of working hours;
- **g.** The freedom to offer services to other entities.

Please be prepared to address these factors for each and every alleged sole proprietor / partner subcontractor utilized by your company and ensure that you maintain your records so that it is clear that the individual is truly a subcontractor in accordance with the Tennessee Workers' Compensation Law, or is registered as exempt from this requirement. Otherwise, these individuals will be deemed to be employees of your company and premium charges will be assessed.

Additional information and other related topics may be obtained from the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation or on their website at www.state.tn.us/labor-wfd/wcomp.html.

IMPORTANT NOTICE – DELAWARE WORKPLACE SAFETY PROGRAM

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

This notice is to inform you of the potential for a Workplace Safety credit in the state of Delaware, as set forth in the Delaware workers' compensation statutes at 19 Del.C.§2379. The Workplace Safety Program gives you the opportunity to qualify for a credit on your Delaware workers' compensation premium by passing worksite safety inspections and continuing to provide a safe workplace.

Employers that pay a minimum annual premium set by the Insurance Commissioner are eligible to apply for the credit. Employers that wish to participate must fill out an application and submit it to the Delaware Department of Insurance. Independent, qualified safety inspectors, under contract to the Delaware Department of Insurance, will then conduct physical inspections of worksites. The employer is responsible for the costs of the inspections. Inspection fees vary according to the rules outlined in the Delaware Basic Manual.

You may call the Delaware Department of Insurance at 302-674-7300, or email the Department's Workplace Safety Program staff at safety@state.de.us, for more detailed information on the program and to request an application.

IMPORTANT NOTICE – USE OF CLAIMS HISTORY IN UNDERWRITING – MD

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

We are notifying you that claims history is considered for purposes of cancelling or refusing to renew your coverage.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

POLICY NUMBER: UB-1T152983-25-14-G

ALASKA POLICYHOLDER NOTICE – ACCESS TO MANUAL INFORMATION

We are required to comply with the rules in the manuals that have been filed for all insurance companies in Alaska by the approved rating organization – the National Council on Compensation Insurance (NCCI) – and subsequently approved by the Alaska Division of Insurance. You may access all filed and approved workers compensation related manuals we use.

ACCESS TO INFORMATION:

Please read your workers compensation policy and all attachments carefully. If you would like more information regarding workers compensation manuals, rules, rates, rating plans, and classifications, please contact NCCI at 800-**NCCI**-123 or at customer_service@ncci.com. NCCI will provide you with printable access to the pertinent manual information free of charge.

In addition, information to enhance your knowledge of workers compensation insurance may be obtained through **ncci.com**. NCCI offers a variety of free Web-based training modules addressing the fundamentals of workers compensation issues, including:

- Classifying a business
- How experience rating works
- How rates are determined

Also, NCCI manuals are available on a subscription basis by contacting NCCI's Customer Service Center at 800-**NCCI**-123 or at **ncci.com**.

Your insurance agent or broker may also answer questions you may have regarding workers compensation manuals, rules, rates, rating plans, and classifications.

IMPORTANT: This notice does not change or amend the policy and endorsements to which it is attached. If any language in this notice is inconsistent with the policy and endorsements, the policy and endorsements control.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

Form 54-2
(Ed. 3-13)

ATTENTION

The enclosed Posting Notices must be displayed in a prominent location in the workplace. It is your responsibility to distribute the applicable Posting Notice(s) to each of your locations and to notify each location that it must post these notices, and keep them posted, in a conspicuous location frequented by your employees.

Posting Notices for the states of Missouri, New Mexico and Texas (Spanish Version) are provided on two separate forms, which must be connected to create one large notice to be posted.

Please contact us at wcppn@travelers.com for assistance in completing the healthcare provider information on Posting Notices for Georgia, Pennsylvania, Tennessee and Virginia.

While carriers are required to provide Posting Notices in AZ, AR, CA, CO, DC, FL, ID, KS, KY, MO, MT, NH and NY, Travelers is providing Posting Notices to you for all states* covered under your policy as a courtesy. All such Posting Notices remain subject to state regulation and are subject to change at any time. For states in which Travelers is providing you with Posting Notices as a courtesy, Travelers assumes no obligation to provide you with revised notice(s) if a state changes its Posting Notice during the current policy term.

If you need additional copies of any Posting Notice, please contact your agent.

* Excluding: DE, GU, IA, NE, ND, OH, PR, SD, VI, WA, WI and WY. The following states do not require posting notices: DE, GU, IA, NE, SD, and WI. The state of OR will provide the posting notice directly. The following are monopolistic states – there are no posting notices for employers' liability: ND, OH, PR, VI, WA and WY.

REPORT OF SIGNIFICANT WORK EXPOSURE TO BODILY FLUIDS OR OTHER INFECTIOUS MATERIAL

(This form is not a claim form, but a report of exposure. Forms to report a claim to the Industrial Commission are available at: www.azica.gov .)

1. Exposed Employee _____ Birth Date _____ Job Title _____
   Last Name First M.I.
2. Address _____ Phone No. _____
3. Employer's Full Name _____
4. Employer's Address _____
5. Date of Exposure _____ Time of Exposure _____
6. Address or Location of Exposure _____
7. Describe the circumstances surrounding the exposure, including (if applicable) personal protective equipment worn and the names of any witnesses to the exposure (be specific)

SAMPLE FORM

Employers should obtain a supply of "REPORTING FORMS" from the Industrial Commission of Arizona. See "Notice to Employees" for address and phone number.

8. What were you exposed to? (Directly or indirectly via bandages, personal items, etc.) Check all that apply.

   ☐ Blood ☐ Vaginal fluid ☐ Broken skin ☐ Urine ☐ Any other fluid(s) containing blood or infectious material (Describe)
   ☐ Semen ☐ Surgical fluid(s) ☐ Mucous membrane ☐ Feces ☐ Airborne/Respiratory/Oral Secretions Other (specify):
   ☐ Saliva ☐ Vomitus ☐ Skin infection (e.g. abscesses, boils, or pus-filled/red/swollen/painful skin lesions)

9. Source person(s) information ☐ Unknown ☐ Known

Name _____ DOB _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

10. What part(s) of your body was exposed to bodily fluids/infectious material? Did exposure take place through your skin or mucous membrane (be specific)? _____

11. Did you have any open cuts, sores, rashes, or other breaks/ruptures in your skin or mucous membrane that were exposed to bodily fluids/infectious material (please describe)? _____

I HAVE GIVEN THIS FORM TO MY EMPLOYER AND HAVE RECEIVED A COPY OF THIS COMPLETE FORM.

EMPLOYEE SIGNATURE DATE _____

Other Required Steps to Establish Prima Facie Claim for HIV, AIDS or Hepatitis C (A.R.S. §§ 23-1043.02, -03; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **You must have blood drawn no later than ten (10) calendar days after exposure.**
3. **You must have blood tested for HIV or Hepatitis C by Antibody Testing no later than thirty (30) calendar days after exposure and test results must be negative.**
4. **You must be tested or diagnosed as HIV positive no later than eighteen (18) months after the exposure, or tested and diagnosed as positive for the presence of Hepatitis C within seven (7) months after the exposure.**
5. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis or positive blood test if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for MRSA (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than thirty (30) days after your exposure.**
2. **For a claim involving MRSA, you must be diagnosed with MRSA within fifteen (15) days after you report in writing to your employer the details of the exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Other Required Steps to Establish Prima Facie Claim for Spinal Meningitis or TB (A.R.S. § 23-1043.04; A.A.C. R20-5-164)

1. **You must file this report with your employer no later than ten (10) days after your exposure.**
2. **For a claim involving spinal meningitis, you must be diagnosed within two (2) to eighteen (18) days of the possible significant exposure and for a claim involving tuberculosis, you must be diagnosed within twelve (12) weeks of the possible significant exposure.**
3. **You must file a workers' compensation claim with the Industrial Commission of Arizona no later than one (1) year from the date of diagnosis if you wish to receive benefits under the workers' compensation system.**

Employer: Keep Original (Notify Carrier) Employee: Keep Copy

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

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

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

WORKERS' COMP INSURANCE
CARRIER THE TRAVELERS INSURANCE COMPANIES

TELEPHONE NUMBER (800) 238-6225

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE.
FOR INFORMATION CALL:
1-800-528-5166
Department of Labor
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131
CODE OF ALABAMA, 1975, § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

TO BE POSTED BY EMPLOYER POLICY NUMBER **UB-1T152983-25-14-G**

ISSUED TO: **WILKES UNIVERSITY**

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation Law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: **THE TRAVELERS INSURANCE COMPANIES.**

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

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

PARA SER COLOCADO POR EL PATRON NUMERO DE POLIZA **UB-1T152983-25-14-G**

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACIÓN PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patrón ha cumplido con las provisiones de la Ley de Compensación para los Trabajadores de Arizona (Título 23, Capítulo 6, Estatutos Enmendados de Arizona) tal como han sido enmendados, y con todas las reglas y ordenanzas de La Comisión Industrial de Arizona hechas en cumplimiento de ésta, y ha asegurado el pago de compensación a los empleados garantizando el pago de dicha compensación por medio de: **THE TRAVELERS INSURANCE COMPANIES**

Además, a todos los empleados se les notifica por este medio que en caso de que específicamente ellos no rechazen las disposiciones de dicha ley obligatoria, se les considerará bajo las leyes de Arizona de haber aceptado las provisiones de dicha ley y de haber escogido aceptar la compensación bajo estos términos; también bajo estos términos los empleados tienen el derecho de rechazar la misma por medio de una notificación por escrito antes de que sufran alguna lesión, todos los formularios o formas en blanco para tal notificación por escrito estarán disponibles para todos los empleados en la oficina de este patrón.

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

KEEP POSTED IN A CONSPICUOUS PLACE.
COLOQUESE EN LUGAR VISIBLE.

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. AN **EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. NO LATER THAN TEN (10) CALENDAR DAYS after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. NO LATER THAN TEN (10) CALENDAR DAYS after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. NO LATER THAN EIGHTEEN (18) MONTHS after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN EVEN** (7) **MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

ICA Form 04-615-01

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Sindrome de la Inmunodeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIE), Sindrome de Inmunodeficiencia Adquirida (SIDA), o Hepatitis C bajo lo provisto por la Ley de Compensación para los Trabajadores de Arizona y las reglas de La Comisión Industrial de Arizona. Tal reclamación debe incluir el suceso de una exposición importante en el trabajo, la que por lo general significa contacto de alguna ruptura de la piel o mucosa del empleado con la sangre, semen, fluido vaginal, fluido(s) quirurgico(s) o cualquier otro fluido de una persona que contenga sangre. **EL EMPLEADO DEBE CONSULTAR A UN MEDICO PARA CONFIRMAR SU RECLAMACION. Las** reclamaciones no pueden resultar de actividad sexual o use ilicito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA o Hepatitis C si reUnen los requisitos siguientes:

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

2. NO MAS **DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patron por escrito los detalles de la exposición como lo proveen las reglas de la Comisión. Las formas de reporte están disponibles en la oficina de este patron o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. Si un empleado elige no llenar la forma de reporte, ese empleado corre el riesgo de perder una reclamación de prima facie.

3. NO MAS **DE DIEZ (10) DIAS DE CALENDARIO** después de una posible exposición importante el empleado va a que le saquen sangre, y **NO** MAS **DE TREINTA (30) DIAS DE CALENDARIO** la sangre es analizada para VIH O HEPATITIS C por medio de análisis de anticuerpos y el análisis resulta negativo.

4. NO MAS **DE DIECIOCHO (18) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevemente y los resultados del análisis son positivos por VIH o el empleado ha sido diagnosticado como positivo por la presencia de VI , o NO MAS **DE SIETE** (7) **MESES** despuesh de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

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

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

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

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;
2. No later than thirty (30) calendar days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;
3. A diagnosis is made within the following time-frames:
   a. For a claim involving MRSA, the employee must be diagnosed with MRSA within fifteen (15) days after the employee reports pursuant to Item No. 2 above;
   b. For a claim involving spinal meningitis, the employee must be diagnosed with spinal meningitis within two (2) to eighteen (18) days of the possible significant exposure; and
   c. For a claim involving TB, the employee is diagnosed with TB within twelve (12) weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

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

ISSUE TO: **WILKES UNIVERSITY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.TRAVELERS.COM/CAMPN**

MPN Effective Date: 02-15-25 MPN Identification number **3195**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

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

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social , or athletic activity** that is not part of your work-related duties.

ISSUE TO: **WILKES UNIVERSITY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.TRAVELERS.COM/CAMPN**

MPN Effective Date: 02-15-25 MPN Identification number **3195**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

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

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social , or athletic activity** that is not part of your work-related duties.

ISSUE TO: **WILKES UNIVERSITY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.TRAVELERS.COM/CAMPN**

MPN Effective Date: 02-15-25 MPN Identification number **3195**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

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

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social , or athletic activity** that is not part of your work-related duties.

ISSUE TO: **WILKES UNIVERSITY**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

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

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. Within one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.TRAVELERS.COM/CAMPN**

MPN Effective Date: 02-15-25 MPN Identification number **3195**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

Claims Administrator **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

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

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social , or athletic activity** that is not part of your work-related duties.

ISSUE TO: **WILKES UNIVERSITY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayor a de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

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

Página web de la MPN: **WWW.TRAVELERS.COM/CAMPN**

Fecha de vigencia de la MPN: 02-15-25 Número de identificación de la MPN: **3195**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

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

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401** . Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representaci n material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ISSUE TO: **WILKES UNIVERSITY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayor a de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

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

Página web de la MPN: **WWW.TRAVELERS.COM/CAMPN**

Fecha de vigencia de la MPN: 02-15-25 Número de identificación de la MPN: **3195**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

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

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401** . Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representaci n material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ISSUE TO: **WILKES UNIVERSITY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayor a de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

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

Página web de la MPN: **WWW.TRAVELERS.COM/CAMPN**

Fecha de vigencia de la MPN: 02-15-25 Número de identificación de la MPN: **3195**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

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

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401** . Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representaci n material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ISSUE TO: **WILKES UNIVERSITY**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayor a de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

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

Página web de la MPN: **WWW.TRAVELERS.COM/CAMPN**

Fecha de vigencia de la MPN: 02-15-25 Número de identificación de la MPN: **3195**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

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

Administrador de Reclamos: **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA**
THE TRAVELERS INSURANCE COMPANIES Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401** . Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representaci n material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission

Revised 10-01-2021

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,
WILKES UNIVERSITY 22 KENDALL CT
NORWALK CT 06850

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

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

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

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

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 5008 **Telephone** (800) 238-6225

City/Town HARTFORD **State** CT **Zip Code** 06102-5008

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

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

Address 111 HIGH RIDGE ROAD **Telephone** (203) 325-3881

City/Town STAMFORD **State** CT **Zip Code** 06905

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

If your employer has listed a location below, you MUST file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

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

Employer Name _____

Address _____ **Telephone** _____

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

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

Date Posted: _____

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

NOTICE
TO EMPLOYEES

State of Connecticut Workers' Compensation Commission

Revised 10-01-2021

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,
WILKES UNIVERSITY NO BUSINESS LOCATION
CT

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

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

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

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

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 5008 **Telephone** (800) 238-6225

City/Town HARTFORD **State** CT **Zip Code** 06102-5008

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

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

Address 999 ASYLUM AVENUE **Telephone** (860) 566-4154

City/Town HARTFORD **State** CT **Zip Code** 06105

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

If your employer has listed a location below, you MUST file your compensation claim there.

When filing your claim, you are also required – by law – to send it by certified mail.

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

Employer Name _____

Address _____ **Telephone** _____

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

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

Date Posted: _____

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

(This notice must be posted in a conspicuous place readily accessible to the employees at all times.)

PANEL OF PHYSICIANS

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expense within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

The insurance company providing coverage for this business under the Workers' Compensation Law is:

Insurer Name: **THE TRAVELERS INSURANCE COMPANIES** Phone: **(800) 238-6225**

Address: **THE TRAVELERS INSURANCE COMPANIES**
P.O. BOX 4614
BUFFALO, NY 14240-4614

Insurer Email: **GAPANELS@travelers.com**

Instructions to injured worker: Review the following physician's contact information and select the provider with whom you would like to receive medical treatment.

Physician's Contact Information: Name, Address, Phone, and website listed below:

1.
2.
3.
4.
5.
6.
7.
8.
9.

(Additional doctors may be added on a separate sheet)

☐ This box is checked if additional physicians are listed on separate sheet.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

WC-P1 (7/2023)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two- thirds of your average weekly wage but not more than $800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $533.33 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $533.33 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $800 per week. A widowed spouse with no children will be paid a maximum of $320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $800 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de $800 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $533.33 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de $533.33 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $800 por semana. Una esposa viuda sin niños se le pagara un máximo de $320,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: https://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-334-6865.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: https://www.sbwc.georgia.gov

CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA $10,000 POR CADA VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19).

ISSUED TO: **WILKES UNIVERSITY**

1T152983

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

PANEL DE DOCTORES
AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los limites de Ia ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de Ia Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de Ia lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas indústriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea Ia regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un tambio de un doctor a otro en Ia lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de Ia Junta Estatal de Compensación de Trabajadores.

La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

Nombre de la compañía de seguranza: **THE TRAVELERS INSURANCE COMPANIES** Telefono: **(800) 238-6225**

Direccion: **THE TRAVELERS INSURANCE COMPANIES**
P.O. BOX 4614
BUFFALO, NY 14240-4614

Correo electronico: **GAPANELS@travelers.com**

Instruccions para el trabajador lesionado: Por favor de revisar la informacion de contacto de los sigientes proveedores medicos y seleccionar el proveedor de quien quiere recibir tratamiento medico.

Informacion de contacto del proveedor medico: Nombre, direccion, telefono, y sitio web enumerados a continuacion abajo:

1.
2.
3.
4.
5.
6.
7.
8.
9.

(Proveedores medicos adicionales se pueden agregar en pagina adicional)

☐ Este cuadro es marcado si es que proveedores medicos adicionales son enumerados en pagina adicional.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: https://www.sbwc.georgia.gov

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

WC-P1 (7/2023)

W10P4G23

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

NOTICE

REGARDING WORKERS'

COMPENSATION INSURANCE

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

WILKES UNIVERSITY

Date 02-15-25

Employer

By

Employer's Authorized Agent

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

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

THE TRAVELERS INSURANCE COMPANIES

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

WORKERS' COMPENSATION

Is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.
2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims **THE PHOENIX INSURANCE COMPANY**			
Business address	**THE TRAVELERS INSURANCE COMPANIES** **P.O. BOX 660456** **DALLAS, TX 75266-0456**		
Business phone	**(800) 238-6225**		
Effective date	**02-15-25**	Termination date	**02-15-26**
Policy number	**UB-1T152983-25-14-G**	Employer's FEIN	**240795506**

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

W12P1O12

WORKERS' COMPENSATION

Is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.
2. **NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims **THE PHOENIX INSURANCE COMPANY**			
Business address	**THE TRAVELERS INSURANCE COMPANIES** **P.O. BOX 660456** **DALLAS, TX 75266-0456**		
Business phone	**(800) 238-6225**		
Effective date	**02-15-25**	Termination date	**02-15-26**
Policy number	**UB-1T152983-25-14-G**	Employer's FEIN	**240795506**

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

W12P1O12

COMPENSACION A LOS TRABAJADORES

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

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

1. **OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los sintomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.
2. **NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
3. **CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

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

   Es contra la ley que el empleador moleste, despida o se niegue a reemplear o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.
4. **MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

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

Para mas información, visite la Red de la Comisión de Compensación para Trabajadores o llame a nuestras oficinas:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Sordo): 312/814-2959

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

Nombre:	**THE PHOENIX INSURANCE COMPANY**		
Dirección de la Compañía:	**THE TRAVELERS INSURANCE COMPANIES** **P.O. BOX 660456** **DALLAS, TX 75266-0456**		
Teléfono de la Compañía:	**(800) 238-6225**		
Fecha efectiva:	**02-15-25**	Fecha de terminación:	**02-15-26**
Número de Póliza:	**UB-1T152983-25-14-G**	FEIN del Empleador:	**240795506**

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

W12P2O12

COMPENSACION A LOS TRABAJADORES

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

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

1. **OBTENGA AYUDA MEDICA.** Por ley, su empleador debe pagar por todos los servicios médicos necesarios que se requieran para aliviar los sintomas de lesión o enfermedad. Si es necesario, el empleador debe pagar por rehabilitación física, mental o profesional dentro de los límites establecidos. El trabajador puede escoger dos doctores, cirujanos u Hospitales. Si el empleador le notifica que tiene un programa de proveedor preferido (PPP) aprobado para la compensación de trabajadores, el PPP cuenta como una de las dos opciones de proveedores.
2. **NOTIFIQUE A SU EMPLEADOR.** Usted debe notificar a su empleador del accidente o enfermedad dentro de 45 días, ya sea por escrito o verbalmente. Para evitar posibles demoras, es recomendable que la nota incluya su nombre, direccion, número telefónico, número de Seguro Social, y una breve descripción de la lesión o enfermedad.
3. **CONOZCA SUS DERECHOS.** Su empleador por ley debe reportar accidentes que resulten en más de tres días de ausencia al trabajo, a la Comisión de Compensación para Trabajadores. Una vez que el accidente es reportado, usted recibirá un manual que explica la ley, beneficios y procedimientos. Si necesita un manual, por favor llame a la Comisión o visite nuestra red.

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

   Es contra la ley que el empleador moleste, despida o se niegue a reemplear o de alguna manera discrimine contra un trabajador por ejercitar sus derechos de conformidad con las leyes que rigen el seguro de accidentes de trabajo de enfermedades profesionales. Si usted hace una demanda fraudulenta, podrá ser castigado por la ley.
4. **MANTENGASE DENTRO DEL LIMITE DE TIEMPO.** Usualmente, las quejas deben ser presentadas dentro de los primeros tres años del accidente o incapacidad de una enfermedad profesional, o dentro de dos años del último pago de compensación de trabajo, lo que sea más reciente. Quejas por neumoconiosis, exposición radiológica, asbestos, o enfermedades similares tienen requerimientos especiales.

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

Para mas información, visite la Red de la Comisión de Compensación para Trabajadores o llame a nuestras oficinas:

Toll-free: 866/352-3033	Chicago: 312/814-6611	Peoria: 309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville: 618/346-3450	Rockford: 815/987-7292	TDD (Sordo): 312/814-2959

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

Nombre:	**THE PHOENIX INSURANCE COMPANY**		
Dirección de la Compañía:	**THE TRAVELERS INSURANCE COMPANIES** **P.O. BOX 660456** **DALLAS, TX 75266-0456**		
Teléfono de la Compañía:	**(800) 238-6225**		
Fecha efectiva:	**02-15-25**	Fecha de terminación:	**02-15-26**
Número de Póliza:	**UB-1T152983-25-14-G**	FEIN del Empleador:	**240795506**

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

W12P2O12

Issued To: **WILKES UNIVERSITY**

WORKERS' COMPENSATION NOTICE

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

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

The Workers' Compensation insurance carrier or the administrator for

WILKES UNIVERSITY
(name of company)

is: THE TRAVELERS INSURANCE COMPANIES
(name of insurance carrier or administrator)

(name of carrier/administrator)

P.O. BOX 660456
(mailing address)

DALLAS, TX 75266-0456
(city, state, zip)

(800) 238-6225
(telephone number)

WC Supervisor
(contact person)

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

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

Issued To: **WILKES UNIVERSITY**

NOTICIA DE COMPENSACION PARA TRABAJADORES

A su empleador le es requerido proveer pagos de beneficios bajo el Acta de Compensación para Trabajadores del Estado de Indiana.

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

La compañía de seguro de compensación del trabajador o el administrador de la compañía

WILKES UNIVERSITY

(nombre de la compañía)

es:

THE TRAVELERS INSURANCE COMPANIES

(nombre de la compañía de seguro/administrador)

P.O. BOX 660456

(dirección)

DALLAS, TX 75266-0456

(ciudad, estado, código postal)

(800) 238-6225

(número de teléfono)

WC Supervisor

(persona de contacto)

Para más información acerca de sus derechos o loss procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

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

WILKES UNIVERSITY

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law
which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.
Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE.

De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado esté trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva**, 20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se est n buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO

THE TRAVELERS INSURANCE COMPANIES — ( ) (800) 238-6225

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 660456
DALLAS, TX 75266-0456

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: https://www.dol.ks.gov/wc
E-mail: KDOL.wc@ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

COMMONWEALTH OF KENTUCKY

WORKERS COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: WILKES UNIVERSITY

Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

Workers Compensation Carrier
(or third party administrator): THE TRAVELERS INSURANCE COMPANIES

Policy #: UB-1T152983-25-14-G , effective 02-15-25 to 02-15-26

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

Telephone: (800) 238-6225 , Contact Person CLAIM MANAGER

EMPLOYEES: If INJURED - NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ IS NOT ☐ participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is _____, its representative is _____ , phone number _____ .

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Department of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The Kentucky Department of Workers Claims at 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS - NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

W16P1P07

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 660456
DALLAS, TX 75266-0456
(800) 238-6225

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

_____

_____

_____

_____

Employer

WILKES UNIVERSITY
84 WEST SOUTH STREET
WILKES-BARRE PA 18766

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003

LOUISIANA
WORKFORCE
COMMISSION

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

  Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
THE TRAVELERS INSURANCE COMPANIES	P.O. BOX 4614 BUFFALO, NY 14240-4614	(800) 238-6225

Employer	Address
WILKES UNIVERSITY	NO BUSINESS LOCATION MA

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

Phone Number:

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

  Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
THE TRAVELERS INSURANCE COMPANIES	P.O. BOX 4614 BUFFALO, NY 14240-4614	(800) 238-6225

Employer	Address
WILKES UNIVERSITY	71 HOWARD ST CAMBRIDGE MA 02139

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

Phone Number:

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

  Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
THE TRAVELERS INSURANCE COMPANIES	P.O. BOX 4614 BUFFALO, NY 14240-4614	(800) 238-6225

Employer	Address
WILKES UNIVERSITY	45 STARLIGHT LN EASTHAM MA 02642

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

Phone Number:

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

NOTICE TO EMPLOYEES

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF INDUSTRIAL ACCIDENTS

IF YOU ARE INJURED ON THE JOB:

- **Immediately notify your employer that you have been injured.**

  Employer HR/Workers' Compensation Contact Phone Number

- **Tell the medical provider that you have been injured at work and give the information below:**

Insurance Carrier	Address	Phone Number
THE TRAVELERS INSURANCE COMPANIES	P.O. BOX 4614 BUFFALO, NY 14240-4614	(800) 238-6225

Employer	Address
WILKES UNIVERSITY	7 FORSYTHIA LN WESTPORT MA 02790

- **If the employer fails to report the injury to the insurer, the employee may file an Employee's Claim (Form 110).**
- **Additional information regarding your rights and eligibility for benefits pursuant the Workers' Compensation law may be obtained by contacting the Department of Industrial Accidents at 617.727.4900 or visiting www.mass.gov/dia.**

IF MEDICAL TREATMENT IS NEEDED:

Injured workers may select their own medical provider. Medical treatment costs that are reasonable, necessary, and related to the work injury will be paid by the above-named insurer.

If medical facility information is provided below, the above-named insurer has a preferred provider arrangement and the insurer has arranged for your initial treatment at:

Medical Facility: Address:

Phone Number:

EMPLOYER: THIS NOTICE MUST BE FILLED OUT AND POSTED WHERE EMPLOYEES CAN READ IT PURSUANT M.G.L. C. 152, SECTIONS 21, 22, 30, AND 75B (2). EMPLOYERS MAY NOT RETALIATE, DISCRIMINATE (IN ACCORDANCE WITH ANY APPLICABLE STATE OR FEDERAL LAWS WHICH INCLUDES IMMIGRATION STATUS), OR PROVIDE FALSE INFORMATION ABOUT THE WORKERS' COMPENSATION PROCESS TO THEIR EMPLOYEES. THIS NOTICE MUST BE UPDATED, POSTED AND REDISTRIBUTED WHEN THERE ARE CHANGES TO THE INFORMATION.

MICHIGAN DEPARTMENT OF
LABOR AND ECONOMIC OPPORTUNITY

State of Michigan
Workers' Disability Compensation Agency

Employees – Know Your Rights!

- **Remember – It is important to report your injury to your employer.**
- **Medical Care**

  You are entitled to reasonable and necessary medical care for work-related injuries or diseases. Employers or their insurance carriers are required by law to provide these services. During the first 28 days of treatment, your employer has the right to choose the physician. After 28 days you are free to change physicians, but you must notify your employer of the change. If you receive treatment from a physician of your choice, you shall obtain and promptly furnish a report to your employer.

  If your employer refuses to provide medical care, you should contact Michigan's Workers' Disability Compensation Agency at its toll-free telephone number: **1-888-396-5041**.

  You should not receive a bill from a health care provider for treatment of a covered work-related injury or illness. If you do receive such a bill, you should contact your employer or the employer's insurance carrier.

- **Wage Loss Benefits**

  You are entitled to weekly workers' compensation benefits if you suffer a wage loss for more than seven consecutive days. These benefits may be claimed as long as a disability and wage loss continue. Generally, the benefit rate is 80% of your after-tax average weekly wage, subject to a maximum rate.

- **Vocational Rehabilitation**

  If you are unable to perform the work that you have done previously, you are entitled to vocational rehabilitation. The number one goal is your return to work with your employer. If you cannot do this or require assistance in finding a new job, vocational rehabilitation services can help.

To be completed by the employer

WILKES UNIVERSITY

Employer Name

Employer Contact Person and Telephone Number

THE TRAVELERS INSURANCE COMPANIES

Workers' Compensation Insurance Carrier Name

If you have questions, please call the
State of Michigan Workers' Disability Compensation Agency
Toll-free 1-888-396-5041
Additional information is on the agency's website at *http://michigan.gov/wdca*.

EMPLOYER: PLEASE POST THIS NOTICE FOR YOUR EMPLOYEES TO SEE!

Michigan Workers' Disability Compensation
Rights & Responsibilities

Each party involved in the workers' compensation system has rights and responsibilities that help ensure the successful application of the law, and ultimately a safe return to work for the employee.

EMPLOYEES

- **Report all injuries to your supervisor immediately!**
- Most workers are covered under workers' compensation from the start of employment.
- Benefits include reasonable & necessary medical care, wage loss benefits, and vocational rehabilitation services.
- A compensable injury is one that has arisen "out of and in the course of employment." In other words, work must cause the disability.
- Workers' compensation is the "exclusive remedy" for work injuries, meaning that in most cases you cannot sue for other damages.
- There is a 7-day waiting period for wage loss benefit payments. If the disability lasts beyond one week, the worker is entitled to benefits as of the eighth day after the injury. If a disability continues for two weeks or longer, then the worker is entitled to be paid compensation for the first week of disability from the date of disablement. Paid medical leave may apply during the 7-day waiting period.
- There is no waiting period for medical benefits; coverage begins at the time of the injury.
- In most cases, wage loss benefits are calculated by taking the average of the highest 39 weeks of the last 52 weeks of gross wages prior to injury. Generally, you should receive 80% of the after-tax value of this average.
- Your first check is due and payable on the 14th day of disability. However, a benefit check is not considered "late" until 30 days after the due date.
- Weekly benefits continue so long as you are disabled, which could be for the rest of your life. However, benefits can be reduced by up to 50% after age 65 at 5% per year up to age 75, or upon receipt of social security retirement benefits.
- If you are only partially disabled, you do have a duty to seek reasonably available work, taking into consideration those limitations (restrictions) from the work-related personal injury or disease.
- If you have **more than one job** covered under the Worker's Disability Compensation Act, you get credit for all wages earned in those jobs.
- **Medical Benefits:** You are entitled to all reasonable and necessary medical care including surgical, hospital, and dental services, as well as crutches, hearing apparatus, chiropractic treatment, and nursing care. These services are provided indefinitely as long as there is a need related to the injury.
- **Choosing A Doctor:** During the first 28 days of treatment, the employer has the right to choose the doctor. After that, you are free to change doctors providing that you notify the employer and insurance company, preferably in writing. You do not need authorization from the insurance company or the employer to be medically treated, as long as the treatment is reasonable and necessary, and your claim is not in dispute.
- **Maintaining Contact**: It is extremely important that you maintain regular contact with your employer throughout the treatment and recovery period so that they are aware of your progress. Provide your employer with updated work status reports and discuss early return to work options.
- **Vocational Rehabilitation:** If you have a work-related injury or illness which prevents you from being able to perform work for which you have previous training or experience, you are entitled to vocational rehabilitation benefits. Vocational rehabilitation can include a variety of professional services designed to help injured workers re-enter the workforce. These services may include job placement assistance, retraining support, or guidance in starting your own business. Vocational rehabilitation services are paid for by the employer/insurance carrier, so in most cases you must have an open workers' compensation claim to receive rehabilitation benefits.
- You may also be eligible for Family Medical Leave Act (FMLA) benefits. If you have questions, you should contact the U.S. Department of Labor.

EMPLOYERS

- **Stay in touch with your employees while they are off work!** Look for appropriate light duty work options and accommodations when possible.
- All public and most private employers in Michigan are covered by workers' compensation. Every employer subject to the Act must provide proof of insurance or be approved for self-insurance to ensure benefits can be paid to its workers should they become injured.
- Eligible employees are covered under workers' compensation from the date of employment.
- There are severe penalties if an employer fails to provide workers' compensation coverage.

EMPLOYER REPORTING

- **All claims must be reported to your insurance carrier.**
- Form WC-100 must be filed with the Workers' Disability Compensation Agency (WDCA) and your insurance carrier immediately upon the disability exceeding 7 consecutive days, death or specific loss. A copy of this form must also be given to the employee.
- You must ensure that reasonable and necessary medical treatment is provided promptly.
- You will need to provide a wage history report to the insurance carrier in order to calculate the correct benefit amount.
- **Minors:** The Act provides that an illegally employed minor is entitled to double compensation if injured.

INSURANCE COMPANIES

- **Prompt and regular payment of benefits is required by law.**
- Form WC-701: Must be filed with the WDCA when wage loss benefits begin, change or stop.
- Form WC-110: Must be filed with the WDCA 3 months post-injury, and every 4 months after, to report on vocational rehabilitation activity.
- Form WC-107: Must be filed with the WDCA if a claim is disputed.
- Medical services rendered are subject to the State of Michigan Health Care Services Rules and Fee Schedule.
- Injured workers are not to be "balance billed" for charges over and above the fee schedule.
- Benefits are not to be stopped for non-cooperation with vocational rehabilitation; a hearing must be requested prior to stoppage.

For more information contact: State of Michigan Workers' Disability Compensation Agency
Toll free: 1-888-396-5041, or visit our website at www.michigan.gov/wdca

Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTMENT OF LABOR AND INDUSTRY

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

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

August 2017

Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTMENT OF LABOR AND INDUSTRY

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

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

August 2017

Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTMENT OF LABOR AND INDUSTRY

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

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

August 2017

Workers' compensation

If you are injured

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

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

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

Workers' compensation pays for

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

What the insurer must do

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

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

Fraud

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

Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTMENT OF LABOR AND INDUSTRY

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

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

August 2017

Compensación laboral

Si usted se lesiona

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

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

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

Compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

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

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

Fraude

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

Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTAMENTO DE TRABAJO E INDUSTRIA

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

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

W22P2H17

Compensación laboral

Si usted se lesiona

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

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

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

Compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

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

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

Fraude

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

Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTAMENTO DE TRABAJO E INDUSTRIA

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

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

W22P2H17

Compensación laboral

Si usted se lesiona

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

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

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

Compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

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

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

Fraude

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

Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTAMENTO DE TRABAJO E INDUSTRIA

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

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

W22P2H17

Compensación laboral

Si usted se lesiona

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

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

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

Compensación laboral paga por lo siguiente

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

Lo que la aseguradora debe hacer

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

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

Fraude

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

Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225

DEPARTAMENTO DE TRABAJO E INDUSTRIA

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

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017

W22P2H17

MISSISSIPPI WORKERS' COMPENSATION NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and maintains workers' compensation insurance coverage with the following:

THE TRAVELERS INSURANCE COMPANIES
(Name of insurance carrier or self-insurance group)

ONE TOWER SQUARE
HARTFORD, CT 06183

(800) 238-6225
(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

TRAVELERS
(Name of third party claims administrator or claims office)

P.O. BOX 4614
BUFFALO, NY 14240-4614

(800) 238-6225
(address & telephone number)

III. This workers' compensation coverage is effective for the following period: 02-15-25 to 02-15-26

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

(Name of employer contact person)

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

2001 M.W.C.C. Notice of Coverage Form

COMPENSACIÓN AL TRABAJADOR DE MISSISSIPPI

NOTIFICACIÓN DE COBERTURA

I. Por favor tome nota que su Empleador está en cumplimiento con los requisitos de la Ley de Compensación al Trabajador de Mississippi, y mantiene seguro de compensación al trabajador con el siguiente:

THE TRAVELERS INSURANCE COMPANIES

(Nombre del asegurador o grupo de seguro propio)

ONE TOWER SQUARE
HARTFORD, CT 06183

(800) 238-6225

(dirección y número de teléfono)

II. Los reclamos individuales de compensación al trabajador serán entregados y procesados por:

TRAVELERS

(Nombre del administrador de reclamos de terceros u oficina de reclamos)

P.O. BOX 4614
BUFFALO, NY 14240-4614

(800) 238-6225

(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:

02-15-25 Hasta **02-15-26**.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

(Nombre de la persona de contacto del empleador)

(Título y departamento o división)

V. Por favor tenga presente que cualquier persona que intencionalmente hace cualquier declaración o representación falsa o engañosa con el propósito de obtener o retener erróneamente cualquier beneficio o pago bajo la Ley de Compensación al Trabajador de Mississippi puede ser acusado de infracción de Miss. Code Ann. §71-3-69 (Rev. 2000) y al ser condenado será sujeto a las penas provistas en ella.

DIVISION OF WORKERS' COMPENSATION

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

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

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456, DALLAS, TX 75266-0456

Phone (800) 238-6225

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____, _____.
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

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

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relive the effects of the injury. This includes all costs for authorized medical treatment, prescription, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurance has the right to choose the healthcare provider or treating physician. you may select a different healthcare provided or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:

For Information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

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

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

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

Steps to Take When an Injury Occurs

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

Workers' Safety

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

Fraud/Noncompliance

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

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material misrepresentation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine up to $10,000. A subsequent violation is a class D felony.

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

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

Missouri Division of Workers', Compensation is an equal opportunity employer/program.Auxiliary aids and services are available upon request to individuals with disabilities.TDD/TTY: 800-735-2966 Relay Missouri: 711

DIVISION OF WORKERS' COMPENSATION

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

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

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456, DALLAS, TX 75266-0456

Phone (800) 238-6225

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____, _____.
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

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

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relive the effects of the injury. This includes all costs for authorized medical treatment, prescription, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurance has the right to choose the healthcare provider or treating physician. you may select a different healthcare provided or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:

For Information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

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

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

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

Steps to Take When an Injury Occurs

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

Workers' Safety

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

Fraud/Noncompliance

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

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material misrepresentation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

Missouri Division of Workers', Compensation is an equal opportunity employer/program.Auxiliary aids and services are available upon request to individuals with disabilities.TDD/TTY: 800-735-2966 Relay Missouri: 711

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Insurance Company, Third Party Administrator, Service Company, or Designated Individual If Self- Insured

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Name THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456, DALLAS, TX 75266-0456

Phone (800) 238-6225

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

_____, _____.
employer representative *phone number*

Failure to do so may jeopardize your ability to receive benefits

2. **Ask your employer to provide medical treatment (your employer/insurer is responsible for providing medical treatment and paying the medical fees and charges unless you choose to treat with another doctor at your own expense without your employer/insurer's approval).**
3. Get more information about the benefits available under the Workers' Compensation Program or about the steps you may take to get the benefits you need. **Visit www.labor.mo.gov/DWC or call 800-775-COMP.**

Benefits for Injured Employees

Medical Care:

The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relive the effects of the injury. This includes all costs for authorized medical treatment, prescription, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately**. The employer/insurance has the right to choose the healthcare provider or treating physician. you may select a different healthcare provided or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:

- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:

If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:

If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC.

Additional Benefits for Occupational Diseases Due to Toxic Exposure - Permanent Total Disability and/or Death:

For Information relating to additional benefits available, please refer to the Division's website at www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

**Make sure your data is turned on and scan the QR Code with your smartphone's camera to go to the Division of Workers Compensation's Website for more information. If you are not redirected, you may need to update your smartphone's operating system or download a QR Code reader app.

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

With some exceptions, all employers with five or more employees, and construction industry employers with one or more employees, are required to insure their workers' compensation liability, either by purchasing a policy or obtaining self-insurance authority. Workers' compensation insurance provides benefits to workers injured on the job. Employers also are required to post this notice in the workplace for employees to view. This poster is required by section 287.127, RSMo, and is available to employers and insurers free of charge by contacting the Division at 800-775-Comp.

Steps to Take When an Injury Occurs

1. Be sure first aid is administered and the employee is taken to a physician or hospital for further medical care, if necessary.
2. Report the injury to the insurance company or Third Party Administrator (TPA) within five days of the date of injury or within five days of the date on which the injury was reported to the employer by the employee, whichever is later. The insurer, TPA, or Division approved self-insurer is responsible for filing a First Report of Injury with the Division of Workers' Compensation **within 30 days** of knowledge of the injury.
3. Pay medical bills related to the work injury for treatment reasonably required to cure and relieve the employee of the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. The employer has the right to choose the healthcare provider or treating physician. (The employee may select a different healthcare provider or treating physician, but if the employee does so, it may be at his/her own expense.)
4. For more liability and insurance information relating to the Workers' Compensation Program, visit www.labor.mo.gov/DWC or call 800-775-COMP.

Workers' Safety

Developing and implementing a comprehensive safety and health program can reduce occupational injuries and help lower workers' compensation costs. Insurance carriers in the state of Missouri must provide safety assistance at the request of the insured employer. The Missouri Department of Labor evaluates these services and provides additional assistance through its Missouri Workers' Safety Program.
Visit www.labor.mo.gov/MWSP or call 573-751-4231 for more information about these programs or for a registry of independent consultants who are certified in the state of Missouri to provide safety assistance.

Fraud/Noncompliance

Employee Fraud – knowingly making a claim for workers' compensation benefits to which an employee knows he/she is not entitled or knowingly presenting multiple claims for the same occurrence with intent to defraud is a class E felony, punishable by a fine of up to $10,000, or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material misrepresentation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine up to $10,000. A subsequent violation is a class D felony.

Insurer Fraud – knowingly and intentionally refusing to comply with workers' compensation obligations to which an insurance company or self-insurer knows an employee is entitled is a class E felony, punishable by a fine of up to $10,000 or double the value of the fraud, whichever is greater. A subsequent violation is a class D felony.

Employer Noncompliance – knowingly failing to insure workers' compensation liability under the law is a class A misdemeanor punishable by a fine of up to three times the annual premium the employer would have paid had it been insured or up to $50,000, whichever is greater. A subsequent violation is a class E felony. An employer who willfully fails to post the notice of workers' compensation at the workplace is guilty of a class A misdemeanor punishable by a fine of $50 to $1,000 or by imprisonment or both fine and imprisonment.

Missouri Division of Workers', Compensation is an equal opportunity employer/program.Auxiliary aids and services are available upon request to individuals with disabilities.TDD/TTY: 800-735-2966 Relay Missouri: 711

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Aseguradora, administrador externo, Compañía de servicios o individuo designado si es autoasegurado

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son coma consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456, DALLAS, TX 75266-0456

Teléfono (800) 238-6225

Pasos a seguir si se lesiona en el trabajo

I. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

_____ , _____ .

representante del empleador *número de teléfono*

No hacerlo puede poner en peligro capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**

3. Obtenga más información de los beneifcios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita

Visite www.labor.mo.gov/DWC o llame al 800–775–2667.

Beneficios para trabajadores lesionados

Cuidados médicos:

El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enefrmedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:

Si un empleado muere en el trabajo. los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias toxicas – disparidad total permanente y/o muerte:

Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

** Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR .

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo. y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

I. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional,si es necesario.

2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.

3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derech o a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)

4. Para obtener más información sobre la responsabilidad o el seguro relacionadas con el Programa de compensación al trabajador, visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compaíñas de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri

Visite www.labor.mo.gov/MWSP o llame al 573- 751- 4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/ no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múlltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E. castigado con una multa de hasta S10,000, o el doble de la cantidad del fraude. lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para con seguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legitimo o quien deliberadamente hace una declaración de material fraudueInto o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A. castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación de los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri:711

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Aseguradora, administrador externo, Compañía de servicios o individuo designado si es autoasegurado

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son coma consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456, DALLAS, TX 75266-0456

Teléfono (800) 238-6225

Pasos a seguir si se lesiona en el trabajo

I. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

_____ , _____ .

representante del empleador *número de teléfono*

No hacerlo puede poner en peligro capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**

3. Obtenga más información de los beneifcios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita

Visite www.labor.mo.gov/DWC o llame al 800–775–2667.

Beneficios para trabajadores lesionados

Cuidados médicos:

El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enefrmedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:

Si un empleado muere en el trabajo. los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias toxicas – disparidad total permanente y/o muerte:

Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

** Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR .

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo. y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

I. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional,si es necesario.

2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.

3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derech o a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)

4. Para obtener más información sobre la responsabilidad o el seguro relacionadas con el Programa de compensación al trabajador, visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compaíñas de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri

Visite www.labor.mo.gov/MWSP o llame al 573- 751- 4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/ no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múlltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E. castigado con una multa de hasta S10,000, o el doble de la cantidad del fraude. lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para con seguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legitimo o quien deliberadamente hace una declaración de material fraudueInto o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A. castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación de los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri:711

DIVISION OF WORKERS' COMPENSATION

Missouri Division of Workers' Compensation
P.O. Box 58, Jefferson City, MO 65102
573-751-4231

Aseguradora, administrador externo, Compañía de servicios o individuo designado si es autoasegurado

Información del empleado

La División de Compensación al Trabajador de Missouri (DWC en inglés) administra programas para trabajadores que han sido lesionados en el trabajo o han sido expuestos a una enfermedad ocupacional que son coma consecuencia del trabajo y durante el mismo. Los Jueces de la Ley Administrativa de la División tienen la autoridad de aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada a los derechos de prestaciones por lesiones a un trabajador.

Nombre THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456, DALLAS, TX 75266-0456

Teléfono (800) 238-6225

Pasos a seguir si se lesiona en el trabajo

I. Notifique a su empleador inmediatamente (se debe proporcionar aviso por escrito en un plazo de 30 días a partir de haber ocurrido la lesión o 30 días cuando se esté bastante consciente de la enfermedad ocupacional relacionada con el trabajo) poniéndose en contacto con

_____ , _____ .

representante del empleador *número de teléfono*

No hacerlo puede poner en peligro capacidad para recibir los beneficios

2. **Busque atención médica (su empleador/aseguradora es responsable de proporcionar tratamiento médico y pagar las cuotas y cargos médicos a menos que elija usted buscar atención con otro médico bajo su propia cuenta sin aprobación previa de su empleador/aseguradora).**

3. Obtenga más información de los beneifcios disponibles bajo el programa de compensación de trabajadores o de los pasos que puede tomar para recibir los beneficios que necesita

Visite www.labor.mo.gov/DWC o llame al 800–775–2667.

Beneficios para trabajadores lesionados

Cuidados médicos:

El empleador o la aseguradora tienen la obligación de proporcionar tratamiento médico y cuidado para curar o aliviar los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. No hay deducibles y todos los costos los paga su empleador o la aseguradora de compensación al trabajador de su empleador. Si usted recibe una factura, **comuníquese con su empleador o con la aseguradora inmediatamente.** El empleador/la aseguradora tiene el derecho a elegir al proveedor del cuidados médicos o al médico que lo atienda. Puede elegir a otro proveedor de cuidados médicos o médico que lo atienda, pero de hacerlo, puede ser a su propia cuenta.

Pago por pérdida de ingresos:

- Si el médico dice que usted no puede regresar a trabajar debido a sus lesiones o para recuperarse de una cirugía, puede que tenga derecho a beneficios por **discapacidad total temporal** (TTD en inglés). Si el médico indica que usted puede realizar un trabajo ligero o modificado y su empleador le ofrece ese trabajo, es posible que no sea elegible para los beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede regresar a trabajar o cuando su tratamiento concluya porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a un trabajo ligero o modificado por menos del pago completo, puede tener derecho a beneficios por **discapacidad parcial temporal**.

Beneficios por discapacidad permanente:

Si la lesión o enefrmedad resulta en una discapacidad permanente, usted puede tener el derecho a recibir beneficios permanentes por discapacidad parcial o discapacidad total.

Beneficios de sobreviviente:

Si un empleado muere en el trabajo. los dependientes sobrevivientes pueden recibir beneficios semanales por muerte pagados a 66 2/3% del salario semanal promedio del empleado fallecido junto con los gastos de funeral hasta $5,000 por parte del empleador o de la aseguradora. Para recibir más información sobre los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para niños sobrevivientes, por favor visite www.labor.mo.gov/DWC.

Beneficios adicionales para las enfermedades ocupacionales causadas por exposición a sustancias toxicas – disparidad total permanente y/o muerte:

Para recibir más información relacionada con los beneficios adicionales disponibles, por favor consulte el sitio web de la División a www.labor.mo.gov/DWC/Injured_Workers/benefits_available.

** Asegure que sus servicio de datos está activado y escanee el código QR Code con la cámara de su teléfono inteligente para ir al sitio web la División de Compensación para Trabajadores para obtener más información. Si no es reorientado, puede que necesite actualizar el sistema operativo de su teléfono inteligente o descargar una aplicación de Lector de Códigos QR .

Ley de Compensación al Trabajador

Funciones y responsabilidades para empleadores y trabajadores

INFORMACIÓN DEL EMPLEADOR

Con algunas excepciones, se requiere todos los empleadores con cinco o más trabajadores, y empleadores de la industria de la construcción con un trabajador o más, para garantizar la compensación al trabajador, ya sea a través de la compra de una póliza de seguro o por adquirir autoridad de autoasegurarse. El seguro por compensación al trabajador proporciona beneficios a los trabajadores lesionados en el trabajo. A los empleadores también se les requiere publicar este aviso en el lugar de trabajo a la vista de todos los empleados. Se requiere poner este cartel de acuerdo a la sección 287.127, RSMo. y el mismo está disponible para todos los empleadores y aseguradoras sin cargo alguno al comunicarse con la División al 800-775-2667.

Pasos a tomar cuando ocurre una lesión

I. Asegúrese de que se administren los primeros auxilios y que se lleve al empleado al médico o al hospital para recibir atención médica adicional,si es necesario.

2. Reporte la lesión a la aseguradora o un Administrador tercero (TPA en inglés) dentro de los cinco días siguientes a la fecha de la lesión o dentro de los cinco días siguientes a la fecha en que fue reportada la lesión al empleador por el trabajador, lo que ocurra después. La Aseguradora, TPA, o autoaseguradora aprobado por la División es responsable para entregar un Informe primero de lesión con la División de Compensación al Trabajador **en un plazo de 30 días** a partir de haberse hecho a conocer la lesión.

3. Pague las cuentas relacionadas a la lesión en el trabajo para curar y aliviar al trabajador de los efectos de la lesión. Esto incluye todos los costos para tratamiento médico autorizado, recetas médicas y aparatos médicos. El empleador tiene derech o a elegir al proveedor de cuidado de la salud o al médico que lo atienda. (Usted como el trabajador puede elegir otro proveedor de cuidados médicos o médico de tratamiento, pero de hacerlo, puede ser por su propia cuenta.)

4. Para obtener más información sobre la responsabilidad o el seguro relacionadas con el Programa de compensación al trabajador, visite www.labor.mo.gov/DWC o llame al 800-775-2667.

Seguridad del trabajador

Desarrollar e implementar un programa integral de seguridad y salud puede reducir las lesiones ocupacionales y ayudan a reducir los costos de compensación al trabajador. Las compaíñas de seguro en el estado de Missouri deben proporcionar ayuda de seguridad a petición del empleador asegurado. El Departamento del Trabajo de Missouri evalúa estos servicios y proporciona ayuda adicional a través de su Programa de Seguridad del Trabajador de Missouri

Visite www.labor.mo.gov/MWSP o llame al 573- 751- 4231 para obtener más información acerca de estos programas o para un registro de asesores independientes certificados en el estado de Missouri para proporcionar ayuda de seguridad.

Fraude/ no cumplimiento

Fraude del trabajador – deliberadamente presentar un reclamo para beneficios de compensación al trabajador a los cuales un empleado sabe que él o ella no tiene derecho o deliberadamente presentar múlltiples reclamos por el mismo evento con el intento de defraudar es un delito mayor clase E. castigado con una multa de hasta S10,000, o el doble de la cantidad del fraude. lo que sea mayor. Una violación posterior es un delito mayor clase D.

Fraude del empleador – deliberadamente distorsionar una clasificación del trabajo del empleado para con seguir seguro por debajo de la tarifa apropiada es un delito menor clase A. Una violación posterior es un delito mayor clase E. Un empleador que deliberadamente hace una declaración falsa o fraudulenta relacionada con el derecho del trabajador a beneficios para disuadir que el trabajador haga un reclamo legitimo o quien deliberadamente hace una declaración de material fraudueInto o representación fraudulenta a negar beneficios a un trabajador es culpable de un delito menor clase A, castigado con una multa de hasta $10,000. Una violación posterior es un delito mayor clase D.

Fraude de la aseguradora – deliberadamente e intencionalmente rehusar cumplir con las obligaciones de compensación al trabajador a las cuales sabe la aseguradora o la autoaseguradora tiene derecho un empleado es un delito mayor clase E, castigado con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una violación posterior es un delito mayor clase D.

No cumplimiento del empleador – Faltar a propósito a asegurar la obligación legal de la compensación al trabajador es un delito menor clase A y también se castiga con una multa civil de hasta tres veces la prima anual que el empleador habría tenido que pagar de estar asegurado, o hasta $50,000, lo que sea mayor. Una violación posterior es un delito mayor clase E. Un empleador que intencionalmente no publica el aviso de compensación al trabajador en el lugar del trabajo es culpable de un delito menor clase A. castigado con una multa de $50 a $10,000, o con prisión o con ambos multa y prisión.

La División de Compensación de los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades.
Hay recursos y servicios disponibles para personas discapacitadas previa solicitud. TDD/TTY: 800-735-2966 Relay Missouri:711

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20, 21). After you have completed the form and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.
2. You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23-a.
3. You may not sue your employer as a result of a work connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1. You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).
2. You are required to file an Employer's First Report of Injury or Occupational Disease, Form No. 8 WCA, with the Labor Commissioner as soon as possible, but no later than five days after learning of the occurrence of any injury (RSA 281-A:53, I). A copy of this form must also be provided to the nearest claims office of your insurance carrier unless the injury requires one-time treatment costing under $2,000 and you pay the medical bill within 30 days. (RSA 281-A:53, I and Lab 504.02). If the injury requires any additional treatment or results in lost time, you must notify your insurance carrier of the injury (Lab 504.02).
3. You are required to report to the Labor Commissioner any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's supplemental Report of Injury, form No 13 WCA, as soon as possible but no later than ten days after the date of knowledge thereof (RSA 281-A:53, I and II).
4. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, and 32.
5. All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employer may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.
6. You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE- Violation of the various provisions of the Workers Compensation Law carries civil penalties, court fines or both.

Rudolph W. Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

The undersigned employer hereby gives notice of compliance with all provisions of the workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A:, as amended

Name of Insurance Company
Or self-insurer:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Name of Employer:
WILKES UNIVERSITY

By

240795506

Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire

WCP-1 (07-18)

W28P1G18

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20, 21). After you have completed the form and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.
2. You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23-a.
3. You may not sue your employer as a result of a work connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1. You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).
2. You are required to file an Employer's First Report of Injury or Occupational Disease, Form No. 8 WCA, with the Labor Commissioner as soon as possible, but no later than five days after learning of the occurrence of any injury (RSA 281-A:53, I). A copy of this form must also be provided to the nearest claims office of your insurance carrier unless the injury requires one-time treatment costing under $2,000 and you pay the medical bill within 30 days. (RSA 281-A:53, I and Lab 504.02). If the injury requires any additional treatment or results in lost time, you must notify your insurance carrier of the injury (Lab 504.02).
3. You are required to report to the Labor Commissioner any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's supplemental Report of Injury, form No 13 WCA, as soon as possible but no later than ten days after the date of knowledge thereof (RSA 281-A:53, I and II).
4. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, and 32.
5. All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employer may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.
6. You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE- Violation of the various provisions of the Workers Compensation Law carries civil penalties, court fines or both.

Rudolph W. Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

The undersigned employer hereby gives notice of compliance with all provisions of the workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A:, as amended

Name of Insurance Company
Or self-insurer:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Name of Employer:
WILKES UNIVERSITY

By

240795506

Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire

WCP-1 (07-18)

W28P1G18

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

A LOS EMPLEADOS

1. Usted está requerido por ley (RSA 281-A: 19) a reportar inmediatamente a su empleador una lesión o enfermedad ocupacional, incluso si usted lo considera menor. Forma No. 8a WCA, Aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito. (RSA 281-A: 20, 21). Después de haber completado el formulario y se lo hizo disponible para él o ella, su empleador debe aceptar el recibo firmando y dándole una copia.
2. Usted tiene el derecho a los servicios de un médico. Este médico estará dentro de la red de cuidados administrados. Si aplica bajo RSA 281-A: 23-a.
3. Usted no puede demandar a su empleador como resultado de una lesión o enfermedad laborar por razón de su elegibilidad para beneficios bajo la ley de compensación al trabajador.

A LOS EMPLEADORES

1. Usted está requerido demostrar este poster porque será uno de los mayores beneficios posibles para sus empleados (RSA 281-A: 4).
2. Usted está requerido un primer informe del empleador sobre la lesión o enfermedad ocupacional, forma No. 8a WCA, con la comisión del trabajo, lo más pronto posible, pero no más tarde de cinco días después de aprender la ocurrencia de cualquier lesión. (RSA 281-A:53, I) Una copia de esta forma tiene que ser proporcionada a las oficina de reclamaciones más cercana de su compañía de seguros a menos que la lesión requiera tratamiento de una sola vez costando menos de $2,000 y que usted pague los costó médicos dentro de los 30 días. (RSA 281-A: 53, I and Lab 504.02). Si la lesión requiere algún tratamiento adicional o resulta en tiempo perdido, usted tiene que notificar a su compañía de seguros sobre la lesión (Lab 504.02)
3. Usted está requerido reportar a la Comisión del Trabajo cualquier discapacidad ocupacional, ya sea total o parcial, de cuatro o más días (RSA 281-A: 22), en el informe Suplementario del empleador sobre lesiones, forma No. 13 WCA, lo más pronto posible, pero no más tarde de 10 días después de la fecha de conocimiento (RSA 281-A:53, I and II).
4. Usted está requerido que proporcione, o ser amueblado, los servicios médicos y hospitalarios razonables, otro cuidado de remediación o rehabilitación vocacional, y varios tipos de indemnización por incapacidad a un empleado lesionado o discapacitado de acuerdo a las leyes RSA 281-A: 23, 25, 26, 28, 29,31, and 32.
5. Todos los empleadores con 5 y más empleados de tiempo completo deben desarrollar las oportunidades alternativas temporales del trabajo para el empleado lesionado en acuerdo con RSA 281-A: 23-b. Los empleadores pueden ser obligado a reinstalar a los empleados que sostienen lesiones compensables de acuerdo con RSA 281-A: 25-a.
6. Usted está requerido a obtener del portador identificado abajo una fuente de todos los formularios de compensación de trabajadores requeridos.

   Aviso — La violación a varias provisiones de la ley de compensación de los trabajadores lleva sanciones civiles, multas de corte o ambos.

Rudolph W . Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

El empleador abajo firmante da aviso de conformidad con todas las disposiciones de la ley de compensación de los trabajadores y de las regulaciones administrativas de la Comisión del Trabajo del Estado de New Hampshire conforme con los estatutos revisados anotados, capitulóó 281-A:, según la enmienda modificación prevista

Nombre de la Compañía de Seguros

O un mismo asegurador:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Este aviso se debe colocado en un lugar visible un su negocio.

Prescrito por la Comisión del Trabajo.

Estado de New Hampshire

Nombre del Empleador:

WILKES UNIVERSITY

240795506

No. De la Identificación Del Empleador

(Si no lo sabe

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

A LOS EMPLEADOS

1. Usted está requerido por ley (RSA 281-A: 19) a reportar inmediatamente a su empleador una lesión o enfermedad ocupacional, incluso si usted lo considera menor. Forma No. 8a WCA, Aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito. (RSA 281-A: 20, 21). Después de haber completado el formulario y se lo hizo disponible para él o ella, su empleador debe aceptar el recibo firmando y dándole una copia.
2. Usted tiene el derecho a los servicios de un médico. Este médico estará dentro de la red de cuidados administrados. Si aplica bajo RSA 281-A: 23-a.
3. Usted no puede demandar a su empleador como resultado de una lesión o enfermedad laborar por razón de su elegibilidad para beneficios bajo la ley de compensación al trabajador.

A LOS EMPLEADORES

1. Usted está requerido demostrar este poster porque será uno de los mayores beneficios posibles para sus empleados (RSA 281-A: 4).
2. Usted está requerido un primer informe del empleador sobre la lesión o enfermedad ocupacional, forma No. 8a WCA, con la comisión del trabajo, lo más pronto posible, pero no más tarde de cinco días después de aprender la ocurrencia de cualquier lesión. (RSA 281-A:53, I) Una copia de esta forma tiene que ser proporcionada a las oficina de reclamaciones más cercana de su compañía de seguros a menos que la lesión requiera tratamiento de una sola vez costando menos de $2,000 y que usted pague los costó médicos dentro de los 30 días. (RSA 281-A: 53, I and Lab 504.02). Si la lesión requiere algún tratamiento adicional o resulta en tiempo perdido, usted tiene que notificar a su compañía de seguros sobre la lesión (Lab 504.02)
3. Usted está requerido reportar a la Comisión del Trabajo cualquier discapacidad ocupacional, ya sea total o parcial, de cuatro o más días (RSA 281-A: 22), en el informe Suplementario del empleador sobre lesiones, forma No. 13 WCA, lo más pronto posible, pero no más tarde de 10 días después de la fecha de conocimiento (RSA 281-A:53, I and II).
4. Usted está requerido que proporcione, o ser amueblado, los servicios médicos y hospitalarios razonables, otro cuidado de remediación o rehabilitación vocacional, y varios tipos de indemnización por incapacidad a un empleado lesionado o discapacitado de acuerdo a las leyes RSA 281-A: 23, 25, 26, 28, 29,31, and 32.
5. Todos los empleadores con 5 y más empleados de tiempo completo deben desarrollar las oportunidades alternativas temporales del trabajo para el empleado lesionado en acuerdo con RSA 281-A: 23-b. Los empleadores pueden ser obligado a reinstalar a los empleados que sostienen lesiones compensables de acuerdo con RSA 281-A: 25-a.
6. Usted está requerido a obtener del portador identificado abajo una fuente de todos los formularios de compensación de trabajadores requeridos.

   Aviso — La violación a varias provisiones de la ley de compensación de los trabajadores lleva sanciones civiles, multas de corte o ambos.

Rudolph W . Ogden, III
Deputy Labor Commissioner

Ken Merrifield
Commissioner of Labor

El empleador abajo firmante da aviso de conformidad con todas las disposiciones de la ley de compensación de los trabajadores y de las regulaciones administrativas de la Comisión del Trabajo del Estado de New Hampshire conforme con los estatutos revisados anotados, capitulóó 281-A:, según la enmienda modificación prevista

Nombre de la Compañía de Seguros

O un mismo asegurador:

THE TRAVELERS INSURANCE COMPANIES
P.O. BOX 4614
BUFFALO, NY 14240-4614
(800) 238-6225

Este aviso se debe colocado en un lugar visible un su negocio.

Prescrito por la Comisión del Trabajo.

Estado de New Hampshire

Nombre del Empleador:

WILKES UNIVERSITY

240795506

No. De la Identificación Del Empleador

(Si no lo sabe

TRAVELERS

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **Insurance Company**

for the period

Beginning 02-15-25 **Ending** 02-15-26

Employer WILKES UNIVERSITY

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

TRAVELERS

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **Insurance Company**

for the period

Beginning 02-15-25 **Ending** 02-15-26

Employer WILKES UNIVERSITY

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

TRAVELERS

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **Insurance Company**

for the period

Beginning 02-15-25 **Ending** 02-15-26

Employer WILKES UNIVERSITY

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

TRAVELERS

AVISO

El empleador abajo firmante, notifica que el pago de compensación a empleados y sus dependientes ha sido asegurado de acuerdo con las disposiciones de la ley de seguros de responsabilidad del empleador, Título 34, Capítulo 15, Artículo 5, Estatutos Revisados del estado New Jersey, asegurándolos con el

(TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **)**

Compañía de Seguros

por el periodo

Comenzando 02-15-25 **Finalizando** 02-15-26

Empleador WILKES UNIVERSITY

De acuerdo con la ley citada anteriormente, aviso de cumplimiento deben publicarse y mantenerse de manera visible en y alrededor los lugares de trabajo del empleador.

TRAVELERS

AVISO

El empleador abajo firmante, notifica que el pago de compensación a empleados y sus dependientes ha sido asegurado de acuerdo con las disposiciones de la ley de seguros de responsabilidad del empleador, Título 34, Capítulo 15, Artículo 5, Estatutos Revisados del estado New Jersey, asegurándolos con el

(TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **)**

Compañía de Seguros

por el periodo

Comenzando 02-15-25 **Finalizando** 02-15-26

Empleador WILKES UNIVERSITY

De acuerdo con la ley citada anteriormente, aviso de cumplimiento deben publicarse y mantenerse de manera visible en y alrededor los lugares de trabajo del empleador.

TRAVELERS

AVISO

El empleador abajo firmante, notifica que el pago de compensación a empleados y sus dependientes ha sido asegurado de acuerdo con las disposiciones de la ley de seguros de responsabilidad del empleador, Título 34, Capítulo 15, Artículo 5, Estatutos Revisados del estado New Jersey, asegurándolos con el

(TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA **)**

Compañía de Seguros

por el periodo

Comenzando 02-15-25 **Finalizando** 02-15-26

Empleador WILKES UNIVERSITY

De acuerdo con la ley citada anteriormente, aviso de cumplimiento deben publicarse y mantenerse de manera visible en y alrededor los lugares de trabajo del empleador.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) **Notice – In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form**
2) **You have the right to information and assistance from an information specialist known as an "Ombudsman" at the Workers' Compensation Administration.**
3) **Claims information – Contact your employer's Claims Representative.**

1) **Aviso. – En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.**
2) **Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.**
3) **Información acerca de Reclamaciones. – Contáctese con el representante de reclamaciones de su compañía.**

Employer's Insurer/Claims Representative:

Name: THE TRAVELERS INSURANCE COMPANIES

Phone #: (800) 238-6225

Address: P.O. BOX 660456 DALLAS, TX 75266-0456

Note: Employer must fill in this insurer/claims representative information.

WCA POSTER (TOP)
PART 1 OF 2
ATTACH BOTTOM OF
POSTER HERE

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency get emergency medical care first.

If you are off work for more than seven days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por, escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Hobbs:	Las Cruces:	Las Vegas:	Roswell:	Santa Fe:
1-866-967-5667	**1-800-568-7310**	**1- 800-934-2450**	**1-800-870-6826**	**1-800-281-7889**	**1-866-311-8587**	**1-505-476-7381**
1-505-841-6000	**1-505-599-9746**	**1-575-397-3425**	**1-575-524-6246**	**1-505-454-9251**	**1-575-623-3997**	

If You Need HELP Call:
Ask for an Ombudsman
Si Usted Necesita Ayuda Llame Al:
Pregunte por un Ombudsman
1 – 8 6 6 – W O R K O M P (1-866-967-5667)
Visit our website at: https://workerscomp.nm.gov

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667
USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR
EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it.
This poster without Notice of Accident forms does not comply with law.
You have other rights and duties under the law.

New Mexico Workers' Compensation
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

11/18
W30P1K18

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE

TO EMPLOYEES

IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Line: 877-632-4996

AVISO DE CUMPLIMIENTO

A EMPLEADOS

INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obten er tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de si ete dìas, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podr a ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague alabogado ó al alabogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

CHAIR/PRESIDENTE
Workers' Compensation Board

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer

WILKES UNIVERSITY
THE TRAVELERS INSURANCE COMPANIES
ONE TOWER SQUARE
HARTFORD, CT 06183
(800) 238-6225

For Insurance Carriers ONLY: Policy No 1T152983
Policy in Force from 02-15-25 *to* 02-15-26

Name of employer (Nombre del patrono)

_____

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

C-105 (9-17)

Workers' Compensation Board
Prescribed of by Chairman
State New York

www.wcb.ny.gov

W31P1I17

FORM 17 Revised 12/2020

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission form s are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's workers' compensation insurance carrier is THE TRAVELERS INSURANCE COMPANIES .
- The insurance policy number is UB-1T152983-25-14-G .
- Your employer's workers' compensation insurance policy is valid from 02-15-25 until 02-15-26 .

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $4,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
  Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

NORTH CAROLINA INDUSTRIAL COMMISION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen.Stat. §97-93).

W32P1L20

FORMA 17 **Revisada 12/2020**

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional.**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia.**
- **Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es** THE TRAVELERS INSURANCE COMPANIES**.**
- **El número de la póliza de seguro es** UB-1T152983-25-14-G**.**
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde** 02-15-25 **hasta** 02-15-26**.**

Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA – (800) 688-8349.

El Empleador deberá:

- **Proveer todos los servicios médicos necesarios al empleado.**
- **Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $4,000.00.**
- **Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.**
- **Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.**

NORTH CAROLINA INDUSTRIAL COMMISSION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen . Stat. § 97-93).

W32P2L20

CC-Form-1A

Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees

All employees of this employer who are entitled to benefits of the Administrative Workers' Compensation Act are hereby notified that this employer has complied with all rules of the Workers' Compensation Commission and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Act. All employees are further notified this employer will furnish first aid, medical, surgical, hospital, optometric, podiatric, chiropractic and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee, as well as payments of compensation to any injured employee or the employee's dependents as provided in the Act.

Any employee who has suffered a compensable injury covered by the Administrative Workers' Compensation Act is entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform work for which the person has previous training or experience.

The Oklahoma Workers' Compensation Commission has a Counselor Division to provide information to injured workers, employers, and other interested persons.

Mediation is available to help resolve certain workers' compensation disputes. For information, call the Counselor Division at 405-522-5308 or In-State Toll Free 855-291-3612.

Signature of Employer

THE TRAVELERS INS COMPANIES, HARTFORD, CT 06183

Insurer Name and Address

02-15-26

Date of Expiration of Insurance Policy (Not applicable to employers authorized to self-insure)

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless oral or written notice is given to the employer within thirty (30) days, the claim for compensation may be forever barred.

The employee may file a claim for compensation with the **WORKERS' COMPENSATION COMMISSION** for an accidental injury, death, cumulative trauma or occupational disease or illness occurring **ON OR AFTER** February 1, 2014. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Commission. The forms are posted on the Commission's website, www.wcc.ok.gov.

A claim for compensation must be filed with the Commission within the time specified by law, or be forever barred. Based on law effective May 28, 2019, a claim for compensation for any accidental injury must be filed with the Commission within one (1) year of the date of injury or, if the employee has received benefits under Title 85 A for the injury, six (6) months from the date of the last issuance of such benefits; a death claim must be filled within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filled within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filled within one (1) year of the date of injury.

Claims for compensation for accidental injury, death, cumulative trauma or occupational disease or illness occurring BEFORE February 1, 2014 may be filed with the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS and are subject to different notice of injury requirements and claims filling deadlines than those for accidental injury, death, cumulative trauma or occupational disease or illness occurring on or after February 1, 2014. Failure to comply with applicable notice requirements and deadlines may operate to forever bar the claim . Contact the WORKERS' COMPENSATION COURT OF EXISTING CLAIMS for additional information.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical, surgical, hospital, optometric, podiatric, chiropractic, and nursing services, medicine, crutches and other apparatus as may be reasonably necessary in connection with the injury received by the employee. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. Within ten (10) days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or medical attention away from the work site, the employer or the employer's representative MUST send a report thereof to the Workers' Compensation Commission via Electronic Data Interchange as specified in Commission rules .

No agreement by any employee to pay any portion of the premium paid by the employer to a carrier or a benefit fund or department maintained by the employer for the purpose of providing compensation or medical services and supplies as required by the workers' compensation laws, shall be valid. Any employer who makes a deduction for such purposes from the pay of any employee entitled to benefits under the workers' compensation laws shall be guilty of a misdemeanor.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tele. 405-522-5308 (OKC) 918-295-3732 (TU) In-State Toll Free 855-291-3612
Web Site www.wcc.ok.gov

Rev. 1 -1 -21
W35P3A21

This notice must be posted and maintained by the employer in one or more conspicuous places on the work premises.

CC-Form-1A *Aviso e Instrucción de Compensación de Trabajadores de Oklahoma para Empresarios y Trabajadores*

Se notifica por la presente a todos los empleados de esta empresa que tengan derecho a los beneficios de la Ley de Compensación para Trabajadores Administrativos que este empleador ha cumplido con todas las reglas de la Comisión de Compensación de Trabajadores, y que este empleador ha asegurado el pago de compensación a todos los empleados y sus dependientes en conformidad con la ley. Asimismo, se notifica a todos los empleados que este empleador proporcionará primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología, quiropráctica, y enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relacióncon la lesión sufrida por el trabajador, así como los pagos de compensación a cualquier empleado lesionado o sus dependientes conforme a lo dispuesto por la ley.

Cualquier empleado que haya sufrido una lesión indemnizable amparado por la Ley de Compensación para Trabajadores Administrativos tiene derecho a los servicios de rehabilitación vocacional, esto incluye la re-capacitación e inserción laboral si el empleado ya no pudiese realizar el trabajo para el cual tuviese formación o experiencia previa como consecuencia de la lesión.

La Comisión de Compensación de Trabajadores de Oklahoma cuenta con una División de Asesoría para proporcionar información a los trabajadores lesionados, empleadores y otras personas interesadas.

Existe la posibilidad de mediación para ayudar a resolver disputas de compensación para ciertos trabajadores. Para obtener más información, llame a la División de Consejería al 405-522-5308 o al número gratuito (dentro del estado) 855-291-3612.

Firma del Empleador

THE TRAVELERS INS COMPANIES, HARTFORD, CT 06183

Nombre y Dirección del Asegurador

02-15-26

Fecha de Vencimiento de la Póliza de Seguro (No aplicable a los empleadores autorizados para auto-asegurarse.)

Responsabilidades del empleado en caso de sufrir una lesión relacionada trabajo

De resultar dañado o afectado por trauma acumulativo o una enfermedad profesional que surja del empleo y en el transcurso de su desempeño, por leve que sea, el empleado debe notificar al empleador inmediatamente. Si este empleador es una sociedad, se debe notificar a cualquier socio. Si este empleador es una corporación, la notificación se hará a cualquier agente o funcionario de la corporación autorizado a recibir tal notificación. Se notificará también a la persona a cargo de los negocios en el lugar de operaciones donde se haya producido la lesión. De no haber notificado verbalmente o por escrito al empleador dentro de los treinta (30) días, el reclamo de indemnización puede prescribir de forma definitiva.

El empleado puede presentar un reclamo de indemnización ante la **COMISIÓN DE COMPENSACIÓN DE TRABAJADORES** por una lesión accidental, muerte, trauma acumulativo o enfermedad profesional o enfermedad accidental que ocurra **EL** 1 de febrero de 2014, **O DESPUÉS** de esa fecha. Este empleador debe suministrar los formularios para presentar un reclamo de compensación, y también se encuentran disponibles en la Comisión de Compensación de Trabajadores. Los formularios se encuentran publicados en el sitio web de la Comisión, www.wcc.ok.gov.

El reclamo de compensación debe ser presentado ante la Comisión en el plazo fijado por la ley, o prescribirá para siempre. En virtud con la Ley vigente al partir del 28 de mayo de 2019, los reclamos de indemnización por cualquier lesión accidental se deben presentarse ante la Comisión dentro de un (1) año transcurrido a partir de la fecha de la lesión; o, si el empleado ha recibido beneficios bajo el Título 85A por la lesión, seis (6) meses desde la fecha de la última emisión de dichos beneficios; un reclamo de muerte debe presentarse dentro de los dos (2) años a partir de la fecha de la muerte; los reclamos de indemnización por males o enfermedades profesionales se deben presentar dentro de los dos (2) años transcurridos a partir de la última exposición perjudicial; y los reclamos de indemnización por trauma acumulativo se deben presentar dentro de un (1) año transcurrido a partir de la fecha de la lesión. Se prohíben los reclamos de indemnización adicional a menos que sean presentados dentro de un (1) año transcurrido a partir del último pago de compensación por discapacidad o dos (2) años desde la fecha de la lesión, el período que sea mayor.

Los reclamos de indemnización por lesiones, muerte, trauma acumulativo o males o enfermedades profesional accidentales que ocurrieran ANTES del 1 de febrero de 2014 se pueden presentar ante el TRIBUNAL DE RECLAMOS EXISTENTES DE COMPENSACIÓN AL TRABAJADOR y estarán sujetos a diferentes requisitos de notificación de la lesión y distintos plazos para presentar reclamos a los requeridos para los correspondientes a lesiones accidentales, muerte, trauma acumulativo o males o enfermedades profesionales que ocurrieran a partir del 1 de febrero de 2014. El incumplimiento de los requisitos y los plazos de notificación aplicables puede resultar en la prescripción definitiva del reclamo. Póngase en contacto con el Tribunal de Reclamos Existentes de Compensación al Trabajador para obtener información adicional.

Responsabilidades del Empleador

El empleador debe proporcionar a los empleados primeros auxilios, servicios médicos, quirúrgicos, hospitalarios, de optometría, podología, quiropráctica, así como servicios de enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con la lesión sufrida por el empleado. Esto es aplicable al cuidado de todas las lesiones y enfermedades que surjan del empleo y el transcurso de su desempeño, independientemente de su carácter. El empleador o su representante, DEBERÁ enviar, dentro de los diez(10) días a partir de la fecha de recepción de la notificación o el conocimiento de la muerte o lesión que resulte en pérdida de tiempo más allá del turno o atención médica fuera del lugar de trabajo del empleado lesionado, un informe sobre esto a la Comisión de Compensación de Trabajadores, a través del Intercambio Electrónico de Datos, como se especifica en las reglas de la Comisión.

Se invalidará cualquier acuerdo hecho por un empleado para pagar cualquier porción de la prima pagada por el empleador a un operador, fondo de prestaciones o departamento mantenido por el empleador con el fin de indemnizar o proveer servicios y suministros médicos, tal como lo requieren las leyes de compensación de los trabajadores. Cualquier empleador que realice una deducción del pago de cualquier empleado con derecho a prestaciones en virtud de las leyes de compensación de los trabajadores para tales propósitos será culpable de un delito menor.

Se invalidará cualquier acuerdo hecho por un empleado para renunciar a los derechos y beneficios de compensación del trabajador.

Toda persona que cometa fraude de compensació n del trabajador, será culpable, de ser condenada, de un delito grave punible con pena de prisión, una multa o ambas.

Comisión de Compensación de Trabajadores
1915 North Stiles Avenue Ste 231
Oklahoma City, Oklahoma 73105-4918
Tel. 405-522-5308 (OKC) · 918-295-3732 (TU) · Línea gratuita (dentro del estado) 855-291-3612
Sitio Web · www.wcc.ok.gov

Enmendado 1-1-21
W35P4A21

Este aviso debe ser publicado y mantenido por el empleador en uno o más lugares visibles en el lugar de trabajo.

WILKES UNIVERSITY

Department of Labor and Training
RHODE ISLAND

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company: THE TRAVELERS INSURANCE COMPANIES

Adjusting Company: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Telephone: (800) 238-6225 **Policy Effective Date:** 02-15-25

In accordance with Rhode Island General Law §28-32-1, the employer must report to the Director of Labor and Training every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity. If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care shall not be considered the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed. Fines may be imposed for noncompliance.

WILKES UNIVERSITY

Department of Labor and Training
RHODE ISLAND

Esta empresa esta sujeta a las estipulaciones delis

ACTA DE COMPENSACION DE TRABAJADORES

del Estado de Rhode Island

Seguro de Compensación de Trabajo: THE TRAVELERS INSURANCE COMPANIES

Compañía Ajustadora: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Teléfono: (800) 238-6225 **Fecha Efectiva de Póliza:** 02-15-25

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, las empresas tienen que reportarle al Director de Trabajo y Entrenamiento cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad. Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

Un empleado lesionado tiene la libertad de escoger al primer proveedor médico. La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atención inmediata, no será considerado el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares visibles para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.

South Carolina
Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Mailing Address

ONE TOWER SQUARE
HARTFORD, CT 06183

Claims Telephone Number

(800) 238-6225

South Carolina
Workers' Compensation

Workers' Compensation Compliance Poster

We are operating under and subject to the South Carolina Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

If you are injured on the job, you should:

1. Notify your employer at once. You cannot receive benefits unless your employer knows you are injured.
2. Tell the doctor your employer sends you to that you are covered by workers' compensation.
3. Notify the Workers' Compensation Provider listed on this poster or the South Carolina Workers' Compensation Commission at 803.737.5700 if you experience undue delays or problems with your claim.

South Carolina
Workers' Compensation Commission
P.O. Box 1715, 1333 Main Street, Suite 500
Columbia, S.C. 29202-1715
803-737-5700
www.wcc.sc.gov

Workers' Compensation Provider Name

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Mailing Address

ONE TOWER SQUARE
HARTFORD, CT 06183

Claims Telephone Number

(800) 238-6225

TENNESSEE WORKERS' COMPENSATION INSURANCE

POSTING NOTICE

How to Report Work-Related Injuries

What should be done if injured at work?

Employee

1. Immediately **report the injury** to the employer representative named below.
2. **Select a treating physician** from a panel provided by your employer.
3. If you have questions or problems, contact the employer representative or the Bureau of Workers' Compensation.

Employer

1. Complete your company's internal "Workplace Injury form" and **notify your workers' compensation insurance company** immediately, even if you have concerns about the validity of the claim.
2. **Offer a panel of physicians** to the employee via Form C-42 available on the Bureau's website. *In cases of emergency, call an ambulance and provide this form as soon as the injured employee has stabilized.*

---

*Printed **name and title** of the employer representative to be notified in the event of a work-related injury*

---

*Printed name of an **alternative employer representative** to be notified in the event of a work-related injury*

***Telephone number** of employer representative to notify in event of a work-related injury*

***Address** of employer representative to notify in event of a work-related injury*

The Tennessee Bureau of Workers' Compensation is available to help both employees and employers.

BWC
Bureau Of **WORKERS' COMPENSATION**

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667
615-532-4810 *TTD: 800-332-2257*
tn.gov/workerscomp

Workers' Compensation law requires this notice to be posted in a conspicuous place at the work site at all times.

(REV. 4/18)
W41P1D18

Authorization No. 337545

RDA 10183

SEGURO DE COMPENSACIÓN A TRABAJADORES DE TENNESSEE

PUBLICACIÓN DE AVISO

Cómo informar de lesiones laborales

¿Qué se debe hacer en caso de lesión laboral?

Empleado

1. **Informe** inmediatamente de **la lesión** al representante del empleador indicado aquí abajo.
2. **Seleccione un médico tratante** del panel provisto por su empleador.
3. Si tiene alguna pregunta o problema, comuníquese con el representante de empleadores de la Oficina de Compensación a Trabajadores.

Empleador

1. Complete el formulario interno de su empresa de "Lesión laboral" y **notifique a su aseguradora de compensación a trabajadores** inmediatamente, incluso aunque tenga dudas acerca de la validez de la reclamación.
2. **Ofrezca un panel de médicos** al empleado a través del Formulario C-42, disponible en el sitio web de la Agencia. *En casos de emergencia, llame a una ambulancia y proporcione este formulario en cuanto el empleado lesionado se haya estabilizado.*

_____

Nombre en letra de molde y título *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Nombre en letra de molde del ***representante del empleador alterno*** *a ser notificado en caso de una lesión laboral*

_____

Número de teléfono *del representante del empleador a ser notificado en caso de una lesión laboral*

_____

Dirección *del representante del empleador a ser notificado en caso de una lesión laboral*

La Oficina de Compensación a Trabajadores de Tennessee está disponible para ayudar a empleados y empleadores.

BWC
Bureau Of **WORKERS' COMPENSATION**

220 French Landing Dr. 1-B
Nashville, TN 37243-2667

800-332-2667

615-532-4810 TTD: 800-332-2257

tn.gov/workerscomp

La ley de Compensación a Trabajadores exige que se publique este aviso en un lugar visible en el centro de trabajo en todo momento.

(REV. 4/18)
W41P2D18

Autorización No. 337545

RDA 10183

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [WILKES UNIVERSITY] has workers' compensation insurance coverage from [THE TRAVELERS INSURANCE COMPANIES] .

In the event of work-related injury or occupational disease. This coverage is effective from [02-15-25] Any injuries or occupational diseases which occur on or after that will be handled by[THE TRAVELERS INSURANCE COMPANIES] An employee or a person acting on the employee's behalf must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll-free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [WILKES UNIVERSITY] tiene cobertura de seguros de compensación para trabajadores con [THE TRAVELERS INSURANCE COMPANIES] para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [02-15-25] Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [THE TRAVELERS INSURANCE COMPANIES].

Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División.El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the **Office of Injured Employee Counsel (OIEC)**. OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: **1-866-393-6432.**

More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

What Is An Ombudsman ? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation.

Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICIN A DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la **Oficina de Asesoría Pública para el Empleado Lesionado** (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con sus reclamacion en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: **1-866-393-6432.**

Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

Programa de Ombudsman

¿Qué es un Ombudsman ? Un Ombudsman es un empleado de OIEC que puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita.

Cada Ombudsman ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation).

Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarlo a usted con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

VERMONT

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

WILKES UNIVERSITY

This employer,_____, has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

THE TRAVELERS INSURANCE COMPANIES

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

Form VWC1

WILKES UNIVERSITY

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.
2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.
3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.
4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.
2. Report the injury to the Commission through your carrier or directly to the Commission.
3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

333 E. Franklin St
Richmond, Virginia 23219

1-877-664-2566
www.workcomp.virginia.gov

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

W45P1A18

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

ISSUED TO: **WILKES UNIVERSITY**

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.
2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.
3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.
4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.
2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.
3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
333 E. Franklin St., Richmond, Virginia 23219
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

NOTICE TO EMPLOYEES

Notice is hereby given that the undersigned employer has secured the payment of compensation under the provisions of the West Virginia Workers' Compensation Law.

The Worker's Compensation insurance carrier/administrator for

WILKES UNIVERSITY

_____ is:

(employer name)

THE TRAVELERS INSURANCE COMPANIES

(name of carrier/administrator)

P.O. BOX 4614

(mailing address)

BUFFALO, NY 14240-4614

(city, state, zip)

(800) 238-6225

(telephone number)

_____

(Name of employer contact person)

This notice must be posted and maintained conspicuously in and about the employer's workplace as required by West Virginia law.

West Virginia law requires that you notify your employer **immediately** upon sustaining a workplace injury.

NOTICE TO EMPLOYEES

Notice is hereby given that the undersigned employer has secured the payment of compensation under the provisions of the West Virginia Workers' Compensation Law.

The Worker's Compensation insurance carrier/administrator for

WILKES UNIVERSITY

_____ is:

(employer name)

THE TRAVELERS INSURANCE COMPANIES

(name of carrier/administrator)

P.O. BOX 4614

(mailing address)

BUFFALO, NY 14240-4614

(city, state, zip)

(800) 238-6225

(telephone number)

_____

(Name of employer contact person)

This notice must be posted and maintained conspicuously in and about the employer's workplace as required by West Virginia law.

West Virginia law requires that you notify your employer **immediately** upon sustaining a workplace injury.

NOTICE TO EMPLOYEES

Notice is hereby given that the undersigned employer has secured the payment of compensation under the provisions of the West Virginia Workers' Compensation Law.

The Worker's Compensation insurance carrier/administrator for

WILKES UNIVERSITY

_____ is:

(employer name)

THE TRAVELERS INSURANCE COMPANIES

(name of carrier/administrator)

P.O. BOX 4614

(mailing address)

BUFFALO, NY 14240-4614

(city, state, zip)

(800) 238-6225

(telephone number)

_____

(Name of employer contact person)

This notice must be posted and maintained conspicuously in and about the employer's workplace as required by West Virginia law.

West Virginia law requires that you notify your employer **immediately** upon sustaining a workplace injury.

DISABILITY COMPENSATION LAW

NOTICE TO EMPLOYEES

Workers' Compensation – You have the right to receive workers' compensation benefits and medical care if you suffer a work- related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance – You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling non-work-related injury/illness or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if a physician properly certifies your inability to work. Generally, you must have worked for an employer in Hawaii at least two weeks before your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care – You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The Department of Labor & Industrial Relations must approve the health care plan and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.

You should claim benefits under this program if a non-work-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu	586-9161 (Workers' Compensation)
	586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo	974-6464
Kona	322-4808
Maui	243-5322
Kauai	274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Jade T. Butay, Director

Department of Labor and Industrial Relations

***You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster. For more information: http://labor.hawaii.gov/labor-law-poster/**

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-8866.

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

THE TRAVELERS INSURANCE COMPANIES
Insurer

P.O. BOX 660456
Street and Number

DALLAS, TX 75266-0456
City | State | Zip Code

For the period from 02-15-25 Through 02-15-26

Adjusting Company

Street and Number

City _____ State _____ Zip Code _____ Telephone (800) 238-6225

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act WILKES UNIVERSITY

Employer

By

Title

Witness

Witness

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE	FAIRBANKS	JUNEAU
3301 Eagle Street	675 7th Avenue	PO Box 115512
Suite 304	Station K	1111 W 8th St Rm 305
Anchorage AK 99503	Fairbanks AK 99701-4531	Juneau AK 99811-5512
(907) 269-4980	(907) 451-2889	(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

Form 07-6120 (Rev 05/2012)

W54P1E12

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 7-19)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3. percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi).

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5, 102(a)
EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company THE TRAVELERS INSURANCE COMPANIES

Address P.O. BOX 660456

DALLAS, TX 75266-0456

Contact Person _____

Phone (800) 238-6225 **Fax:** _____

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 7-19)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible**.

(1) **NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE**: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 20 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, 20 días a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 10 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) **SIGA LAS INSTUCCIONES DE SU EMPLEADOR** para conseguir ayuda médica y siga las instrucciones del doctor.

(3) **BENEFICIOS MÉDICOS:** El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) **BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.

Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.

Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.1. Puede acceder a nuestro sitio web en http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi)

2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.

3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.

4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.

5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5, 102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía THE TRAVELERS INSURANCE COMPANIES

Dirección P.O. BOX 660456

DALLAS, TX 75266-0456

Persona de Contacto _____

Teléfono (800) 238-6225 Fax _____

Correo electrónico _____

NAMED INSURED: WILKES UNIVERSITY

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF THE ARIZONA OVERSIZED POSTING NOTICES

W02P2 – (ENGLISH)

W02P3 – (SPANISH)

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: WILKES UNIVERSITY

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

GUNTHER OPERATOR:-

MANUALLY INSERT 4 COPIES OF W05P2

COLORADO OVERSIZED POSTING NOTICE WC50

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: WILKES UNIVERSITY

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF THE FLORIDA OVERSIZED POSTING NOTICES

W09P1 — (ENGLISH)

AND

W09P2 — (SPANISH)

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER–Name:	WILKES UNIVERSITY
Address:	84 WEST SOUTH STREET
	WILKES-BARRE PA 18766
CARRIER–Name:	THE TRAVELERS INSURANCE COMPANIES
Address:	VARIES BY LOCATION
AGENT–Name:	RIGGS COUNSELMAN MICHAEL
POLICY NUMBER:	UB-1T152983-25-14-G

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: WILKES UNIVERSITY

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W18P1

MAINE OVERSIZED POSTING NOTICES

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

WILKES UNIVERSITY

GUNTHER OPERATOR:

MANUALLY INSERT 2 COPIES OF W19P1

MARYLAND OVERSIZED POSTING NOTICES

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER–Name: WILKES UNIVERSITY
Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

Telephone No. (507) 408-4200 FEIN: 240795506

CARRIER–Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No. (800) 238-6225

POLICY NUMBER: 1T152983

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

NAMED INSURED: WILKES UNIVERSITY

POLICY NUMBER: UB-1T152983-25-14-G

EFFECTIVE DATE: 02-15-25

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W27P1

NEVADA OVERSIZED POSTING NOTICES

ATTACH NEVADA STICKERS

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.

01-08-25

MANUAL INSERT INFORMATION

STICKER LABELS AND/OR POSTING NOTICES FOR MANUAL INSERT

FOR POLICY PRINTED IN JOB #:

Named Insured: WILKES UNIVERSITY

Policy Number: UB-1T152983-25-14-G

Effective Date: 02-15-25

MANUAL INSERT INFORMATION

EMPLOYER – Name: WILKES UNIVERSITY

Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

AGENT – Name: RIGGS COUNSELMAN MICHAEL Eff. Date: 02-15-25

POLICY NUMBER: UB-1T152983-25-14-G Exp. Date: 02-15-26

EMPLOYER – Name: WILKES UNIVERSITY

Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

AGENT – Name: RIGGS COUNSELMAN MICHAEL Eff. Date: 02-15-25

POLICY NUMBER: UB-1T152983-25-14-G Exp. Date: 02-15-26

EMPLOYER – Name: WILKES UNIVERSITY

Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

Telephone No: (507) 408-4200 FEIN: 240795506

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No: (800) 238-6225

POLICY NUMBER: 1T152983

EMPLOYER – Name: WILKES UNIVERSITY

Address: 84 WEST SOUTH STREET
WILKES-BARRE PA 18766

Telephone No: (507) 408-4200 FEIN: 240795506

CARRIER – Name: THE TRAVELERS INSURANCE COMPANIES

Telephone No: (800) 238-6225

POLICY NUMBER: 1T152983

ISSUED TO:	WILKES UNIVERSITY
INSURER/ ADMINISTRATOR:	CLAIM MANAGER
CONTACT PERSON:	CLAIM MANAGER
Address:	P.O. BOX 71000 LAS VEGAS, NV 89170-1000
Telephone No.	(800) 238-6225