MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

UNIVERSITY OF MAINE SYSTEM
UNIVERSITY SERVICES: RISK MGT
46 UNIVERSITY DR
ROBINSON HALL
AUGUSTA ME 04330

POLICY INFORMATION PAGE ENDORSEMENT

The following item(s)

- [ ] Insured's Name (WC 89 06 01)
- [ ] Policy Number (WC 89 06 02)
- [ ] Effective Date (WC 89 06 03)
- [ ] Expiration Date (WC 89 06 04)
- [ ] Insured's Mailing Address (WC 89 06 05)
- [ ] Experience Modification (WC 89 04 06)
- [ ] Producer's Name (WC 89 06 07)
- [ ] Change in Workplace of Insured (WC 89 06 08)
- [ ] Insured's Legal Status (WC 89 06 10)
- [ ] Item 3.A. States (WC 89 06 11)
- [ ] Item 3.B. Limits (WC 89 06 12)
- [ ] Item 3.C. States (WC 89 06 13)
- [ ] Item 3.D. Endorsement Numbers (WC 89 06 14)
- [x] Item 4.* Class, Rate, Other (WC 89 04 15)
- [ ] Interim Adjustment of Premium (WC 89 04 16)
- [ ] Carrier Servicing Office (WC 89 06 17)
- [ ] Interstate/Intrastate Risk ID Number (WC 89 06 18)
- [ ] Carrier Number (WC 89 06 19)
- [ ] Issuing Agency/Producer Office Address (WC 89 06 25)

is changed to read:

ENDORSED TO APPLY RATE REVISION OF DC WORKERS COMPENSATION POLICY HOLDER SURCHARGE.

*Item 4. Change To:

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium $ 4,388

Minimum Premium $ 315 Deposit Premium $ 4,388

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 10/01/2020 Policy No. 310 2805098 Endorsement No. 001
Insured UNIVERSITY OF MAINE SYSTEM Policy Period 10/01/2020 To 10/01/2021
NCCI Carrier Code 38563 Premium Including Endorsement $ 4,388.00 Endorsement Premium $ 2.00
Insurance Company MEMIC Indemnity Company

Countersigned by ______________________

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MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
310 2805098	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	
Renewal of	**Transaction**	
Renewal of 310 2805098	AMENDED DECLARATION	

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier #	FEIN #:	Risk ID #	Unemployment ID #	Entity of Insured
38563	016000769	SEE EXT OF INFO		CORPORATION

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: AZ, AK, AR, CO, DC, DE, GA, HI, IA, ID, IN, KY, LA, MI, MO, MT, NC, NE, NM, NV, OK, OR, SD, TX, UT, WI

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here.
   AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

SEE EXTENSION OF INFORMATION PAGE

Minimum Premium $ 315

Total Estimated Annual Premium $ 4,388

Expense Constant $ 220

Deposit Premium $ 4,388

Assessments and Taxes $ 62

Countersigned this day of
Issued Date: 10/28/2020
Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551

Authorized Representative

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ARIZONA					
	LOC: 00001 ADDRESS: 123 EL CAMINO REAL PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	23,746.00	0.330000	$	78
	MANUAL PREMIUM			**$**	**78**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	78.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	79.00	0.680000	$	-25
9740	TERRORISM	23,746.00	0.010000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	23,746.00	0.010000	$	2
	STATE TOTAL			**$**	**58**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ARKANSAS					
LOC: 00002 ADDRESS: 1108 EVERGREEN LANE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	10,881.00	0.290000	$	32
	MANUAL PREMIUM			**$**	**32**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	32.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	32.00	0.680000	$	-10
9740	TERRORISM	10,881.00	0.007000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	10,881.00	0.010000	$	1
	STATE TOTAL			**$**	**24**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
COLORADO					
LOC: 00003 ADDRESS: 8083 AMMONS WAY PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	85,997.00	0.540000	$	464
	MANUAL PREMIUM			**$**	**464**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	464.00	0.011000	$	5
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	469.00	0.680000	$	-150
9887	SCHEDULE CREDIT	319.00	0.100000	$	-32
9740	TERRORISM	85,997.00	0.008000	$	7
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	85,997.00	0.020000	$	17
	STATE TOTAL			**$**	**311**

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

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

LOC: 00004 ADDRESS: 800 N FRENCH STREET
PERIOD: 10/01/2020 TO 10/01/2021

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
965	COLLEGE OR SCHOOL NOC - ALL EMPLOYEES INCLUDING OFFICE EXCEPT WORKFARE PROGRAM EMPLOYEES AND SEPARATELY LOCATED AND STAFFED PUBLIC LIBRARIES	* IF ANY *	0.580000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9885	MERIT RATING CREDIT		0.950000	$	0
9740	TERRORISM		0.013000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$	0
	STATE TOTAL			**$**	

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
DISTRICT OF COLUMBIA					
LOC: 00005 ADDRESS: 5TH STREET NW					
PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	82,922.00	0.280000	$	232
	MANUAL PREMIUM			**$**	**232**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	232.00	0.011000	$	3
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	235.00	0.680000	$	-75
9740	TERRORISM	82,922.00	0.109000	$	90
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	82,922.00	0.020000	$	17
DC SRG	WORKERS COMPENSATION POLICY HOLDER SURCHARGE	267.00	0.009100	$	2
	STATE TOTAL			**$**	**269**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
GEORGIA					
LOC: 00007 ADDRESS: 55 TRINTY AVE SW PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	74,337.00	0.430000	$	320
	MANUAL PREMIUM			**$**	**320**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	320.00	0.011000	$	4
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	324.00	0.680000	$	-104
9740	TERRORISM	74,337.00	0.009000	$	7
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	74,337.00	0.020000	$	15
	STATE TOTAL			**$**	**242**

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
IDAHO					
LOC: 00008 ADDRESS: 1632 S RIVERSTONE LANE APT 203 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	63,776.00	0.620000	$	395
	MANUAL PREMIUM			**$**	**395**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	395.00	0.011000	$	4
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	399.00	0.680000	$	-128
9740	TERRORISM	63,776.00	0.010000	$	6
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	63,776.00	0.010000	$	6
	STATE TOTAL			**$**	**283**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
INDIANA					
LOC: 00009 ADDRESS: 6422 RALSTON AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,000.00	0.290000	$	9
	MANUAL PREMIUM			**$**	**9**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	9.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	9.00	0.680000	$	-3
9740	TERRORISM	3,000.00	0.010000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,000.00	0.010000	$	0
0935	SECOND INJURY FUND ASSESSMENT	6.00	0.008300	$	0
	STATE TOTAL			**$**	**6**

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(A Stock Company)
650 Elm Street Suite 401
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
IOWA					
LOC: 00010 ADDRESS: 815 PINON DRIVE #212 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	19,400.00	0.490000	$	95
	MANUAL PREMIUM			**$**	**95**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	95.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	96.00	0.680000	$	-31
9740	TERRORISM	19,400.00	0.010000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	19,400.00	0.010000	$	2
	STATE TOTAL			**$**	**69**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
KENTUCKY					
LOC: 00011 ADDRESS: 3840 NADIA LANE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,852.00	0.240000	$	9
	MANUAL PREMIUM			**$**	**9**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	9.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	9.00	0.680000	$	-3
9740	TERRORISM	3,852.00	0.006000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,852.00	0.010000	$	0
KY SRG	KENTUCKY WORKERS COMPENSATION SURCHARGE	6.00	0.064100	$	0
	STATE TOTAL			**$**	**6**

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
LOUISIANA				
LOC: 00012 ADDRESS: 408 KEES CIRCLE PERIOD: 10/01/2020 TO 10/01/2021				
8868	ARCHAELOGIST RESEARCH	* IF ANY *	0.490000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.014000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
9740	TERRORISM		0.007000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$ 0
	STATE TOTAL			**$**

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MICHIGAN					
LOC: 00013 ADDRESS: 3477 CLAY ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE-PROFESSIONAL EMPLOYEES	117,645.00	0.290000	$	341
	MANUAL PREMIUM			**$**	**341**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	341.00	0.020000	$	7
9740	TERRORISM ACT SURCHARGE	117,645.00	0.032000	$	38
	STATE TOTAL			**$**	**386**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MISSOURI					
LOC: 00015 ADDRESS: 2017 YORKTOWN DRIVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,852.00	0.570000	$	22
	MANUAL PREMIUM			**$**	**22**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	22.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	22.00	0.680000	$	-7
9740	TERRORISM	3,852.00	0.008000	$	0
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	15.00	0.030000	$	0
MO SSS	MO SIF SUPPLEMENTAL SCHG	15.00	0.020000	$	0
	STATE TOTAL			**$**	**15**

MEMIC Indemnity Company
(A Stock Company)
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MONTANA					
LOC: 00014 ADDRESS: 3845 VINAL LAKE ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	18,850.00	0.770000	$	145
	MANUAL PREMIUM			**$**	**145**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	145.00	0.011000	$	2
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	147.00	0.680000	$	-47
9740	TERRORISM	18,850.00	0.009000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	18,850.00	0.020000	$	4
0935	MONTANA SECOND INJURY FUND SURCHARGE	106.00	0.004368	$	0
0934	STAY-AT-WORK/RETURN-TO-WORK SURCHARGE	106.00	0.000000	$	0
0939	WC REGULATORY ASSESSMENT SURCHARGE	106.00	0.016159	$	2
9616	MT OCC S&H REG ASSESSMENT SRG	106.00	0.008076	$	1
	STATE TOTAL			**$**	**109**

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEBRASKA					
LOC: 00035 ADDRESS: 2411 THIRD AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8,616.00	0.330000	$	28
	MANUAL PREMIUM			**$**	**28**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	28.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	28.00	0.680000	$	-9
9740	TERRORISM	8,616.00	0.006000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	8,616.00	0.010000	$	1
	STATE TOTAL			**$**	**21**

MEMIC Indemnity Company
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEVADA					
LOC: 00030 ADDRESS: 4181 BROOKVIEW WAY PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	6,136.00	0.610000	$	37
	MANUAL PREMIUM			**$**	**37**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	37.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	37.00	0.680000	$	-12
9740	TERRORISM	6,136.00	0.058000	$	4
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	6,136.00	0.010000	$	1
	STATE TOTAL			**$**	**30**

Issued Date: 10/28/2020

MEMIC Indemnity Company
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650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEW MEXICO					
LOC: 00016 ADDRESS: 3939 RIO GRAND BLVD NW #7 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM		0.008000	$	0
	STATE TOTAL			**$**	

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NORTH CAROLINA					
LOC: 00017 ADDRESS: 1400 CENTRAL AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	35,923.00	0.260000	$	93
	MANUAL PREMIUM			**$**	**93**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	93.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	94.00	0.680000	$	-30
9740	TERRORISM	35,923.00	0.006000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	35,923.00	0.010000	$	4
	STATE TOTAL			**$**	**70**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
OKLAHOMA				
LOC: 00018 ADDRESS: 722 N PORTER AVE PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.014000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
9740	TERRORISM		0.008000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.020000	$ 0
	STATE TOTAL			**$**

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OREGON

LOC: 00019 ADDRESS: 20025 SILVER FALLS HWY SE
PERIOD: 10/01/2020 TO 10/01/2021

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
8868	SCHOOLS- PROFESSIONAL & CLERICAL	9,066.00	0.340000	$	31
	MANUAL PREMIUM			**$**	**31**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	31.00	0.004000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	31.00	0.680000	$	-10
9740	TERRORISM	9,066.00	0.008000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	9,066.00	0.020000	$	2
OR SRG	OREGON WORKERS COMPENSATION SURCHARGE	24.00	0.084000	$	2
OR IGA	OREGON INSURANCE GUARANTEE ASSOCIATION	24.00	0.000000	$	0
	STATE TOTAL			**$**	**26**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
SOUTH DAKOTA					
LOC: 00034 ADDRESS: 503 WEST APPLE ST PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,927.00	0.420000	$	16
	MANUAL PREMIUM			**$**	**16**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	16.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	16.00	0.680000	$	-5
9740	TERRORISM	3,927.00	0.008000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,927.00	0.020000	$	1
SDPS	SOUTH DAKOTA POLICYHOLDER SURCHARGE		0.000000	$	14
	STATE TOTAL			**$**	**26**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
TEXAS					
LOC: 00020 ADDRESS: 703 E 3RD ST PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	240,231.00	0.280000	$	673
	MANUAL PREMIUM			**$**	**673**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	673.00	0.014000	$	9
9848	TO EQUAL MINIMUM PREMIUM (E L)		0.000000	$	91
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	773.00	0.680000	$	-247
9740	TERRORISM ACT SURCHARGE	240,231.00	0.024000	$	58
	STATE TOTAL			**$**	**584**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
UTAH				
LOC: 00023 ADDRESS: 112E BROADWAY PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	21,960.00	0.220000	$ 48
	MANUAL PREMIUM			**$ 48**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	48.00	0.011000	$ 1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	49.00	0.680000	$ -16
9740	TERRORISM	21,960.00	0.008000	$ 2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	21,960.00	0.020000	$ 4
	STATE TOTAL			**$ 39**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
WISCONSIN				
LOC: 00024 ADDRESS: 2 S PINCKNEY STREET PERIOD: 10/01/2020 TO 10/01/2021				
8868	SCHOOL: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.530000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
0900	EXPENSE CONSTANT			$ 220
9740	TERRORISM		0.020000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$ 0
	STATE TOTAL			**$ 220**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
HAWAII				
LOC: 00021 ADDRESS: 2272 KALAKAUA AVE PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
9740	TERRORISM		0.015000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$ 0
	STATE TOTAL			**$**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ALASKA					
	LOC: 00022 ADDRESS: 4732 OMALLY ROAD PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.830000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM ACT SURCHARGE		0.007000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$	0
AK INS	AK INS GUARANTY ASSOC		0.005000	$	0
	STATE TOTAL			**$**	
	POLICY TOTAL			**$**	**4,388**

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00001	UNIVERSITY OF MAINE SYSTEM	123 EL CAMINO REAL SEDONA AZ 85201-0000	
00025	UNIVERSITY OF MAINE SYSTEM	4580 N VIA MADRE TUCSON AZ 85749-0000	
00002	UNIVERSITY OF MAINE SYSTEM	1108 EVERGREEN LANE BLYTHEVILLE AR 72315-0000	
00003	UNIVERSITY OF MAINE SYSTEM	8083 AMMONS WAY ARVADA CO 75011-0000	
00004	UNIVERSITY OF MAINE SYSTEM	800 N FRENCH STREET WILMINGTON DE 19801-0000	
00005	UNIVERSITY OF MAINE SYSTEM	5TH STREET NW WASHINGTON DC 20001-0000	
00007	UNIVERSITY OF MAINE SYSTEM	55 TRINTY AVE SW ATLANTA GA 30303-0000	
00008	UNIVERSITY OF MAINE SYSTEM	1632 S RIVERSTONE LANE APT 203 BOISE ID 83701-0000	
00009	UNIVERSITY OF MAINE SYSTEM	6422 RALSTON AVE INDIANAPOLIS IN 47512-0000	
00010	UNIVERSITY OF MAINE SYSTEM	815 PINON DRIVE #212 AMES IA 50010-0000	
00011	UNIVERSITY OF MAINE SYSTEM	3840 NADIA LANE LEXINGTON KY 40514-0000	
00012	UNIVERSITY OF MAINE SYSTEM	408 KEES CIRCLE LAFAYETTE LA 70501-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00013	UNIVERSITY OF MAINE SYSTEM	3477 CLAY ROAD ROTHBURY MI 49452-0000	
00014	UNIVERSITY OF MAINE SYSTEM	3845 VINAL LAKE ROAD TROY MT 59935-0000	
00015	UNIVERSITY OF MAINE SYSTEM	2017 YORKTOWN DRIVE CAPE GIRARDEAU MO 63701-0000	
00016	UNIVERSITY OF MAINE SYSTEM	3939 RIO GRAND BLVD NW #7 ALBUQUERQUE NM 87107-0000	
00017	UNIVERSITY OF MAINE SYSTEM	1400 CENTRAL AVE CHARLOTTE NC 28205-0000	
00018	UNIVERSITY OF MAINE SYSTEM	722 N PORTER AVE NORMAN OK 73071-0000	
00019	UNIVERSITY OF MAINE SYSTEM	20025 SILVER FALLS HWY SE SUBLIMITY OR 97385-0000	
00020	UNIVERSITY OF MAINE SYSTEM	703 E 3RD ST TYLER TX 75201-0000	
00021	UNIVERSITY OF MAINE SYSTEM	2272 KALAKAUA AVE HONOLULU HI 96815-0000	UIAN: 0199999999
00022	UNIVERSITY OF MAINE SYSTEM	4732 OMALLY ROAD ANCHORAGE AK 99507-0000	
00023	UNIVERSITY OF MAINE SYSTEM	112E BROADWAY SALT LAKE CITY UT 84111-0000	UIAN: 0199999
00024	UNIVERSITY OF MAINE SYSTEM	2 S PINCKNEY STREET MADISON WI 53703-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00026	UNIVERSITY OF MAINE SYSTEM	511 DIRKSEN SENATE BLDG WASHINGTON DC 20001-0000	
00027	UNIVERSITY OF MAINE SYSTEM	100 INDEPENDENCE AVE SW WASHINGTON DC 20001	
00028	UNIVERSITY OF MAINE SYSTEM	1244 G STREET NE WASHINGTON DC 20001-0000	
00030	UNIVERSITY OF MAINE SYSTEM	4181 BROOKVIEW WAY LAS VEGAS NV 89121	
00034	UNIVERSITY OF MAINE SYSTEM	503 WEST APPLE ST PARKSTON SD 57366	
00035	UNIVERSITY OF MAINE SYSTEM	2411 THIRD AVE SCOTTSBLUFF NE 69361	

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NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM	CORPORATION	016000769

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
AZ	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AZ	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AZ	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AZ	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AZ	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AZ	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
AZ	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AZ	*WC020601B	(8/20)	AZ CANC. & NONRENEWAL ENDT
AR	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AR	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AR	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AR	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
AR	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AR	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AR	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
AR	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AR	WC030601B	(3/18)	AR AMENDATORY ENDORSEMENT
AR	WC990403	(7/11)	INSTALLMENT FEE
CO	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
CO	WC000404	(4/84)	PENDING RATE CHANGE ENDT
CO	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
CO	WC000419	(1/01)	PREMIUM DUE DATE ENDT
CO	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
CO	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
CO	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
CO	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
CO	WC050402	(11/90)	CLASSIFICATION ENDT
CO	WC050403	(3/93)	PREM CREDIT FOR CERTIFIED RISK
CO	WC990403	(7/11)	INSTALLMENT FEE
DE	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
DE	WC000404	(4/84)	PENDING RATE CHANGE ENDT
DE	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT

* Indicates that this endorsement is added or modified.

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State	Form Nbr.	Ed. Date	Description
DE	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
DE	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
DE	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
DE	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
DE	WC070408	(7/99)	DE MERIT RATING PLAN ENDORSMNT
DE	WC070601	(7/88)	DE NONRENEWAL ENDT
DE	WC990403	(7/11)	INSTALLMENT FEE
DC	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
DC	WC000404	(4/84)	PENDING RATE CHANGE ENDT
DC	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
DC	WC000419	(1/01)	PREMIUM DUE DATE ENDT
DC	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
DC	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
DC	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
DC	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
DC	WC080601	(4/84)	DC CANCELLATION ENDT
DC	WC990403	(7/11)	INSTALLMENT FEE
GA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
GA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
GA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
GA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
GA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
GA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
GA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
GA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
GA	WC100601C	(7/18)	GA CANC,NON-RENEWAL & RN ENDT
GA	WC990403	(7/11)	INSTALLMENT FEE
ID	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
ID	WC000404	(4/84)	PENDING RATE CHANGE ENDT
ID	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
ID	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
ID	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
ID	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
ID	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
ID	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
ID	WC990403	(7/11)	INSTALLMENT FEE
IN	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
IN	WC000404	(4/84)	PENDING RATE CHANGE ENDT

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State	Form Nbr.	Ed. Date	Description
IN	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
IN	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
IN	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
IN	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
IN	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
IN	WC990403	(7/11)	INSTALLMENT FEE
IA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
IA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
IA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
IA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
IA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
IA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
IA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
IA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
IA	WC990403	(7/11)	INSTALLMENT FEE
KY	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
KY	WC000404	(4/84)	PENDING RATE CHANGE ENDT
KY	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
KY	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
KY	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
KY	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
KY	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
KY	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
KY	WC160305	(6/07)	KY PART ONE W/C INS ENDT
KY	WC160601	(12/97)	KY CANCELATION/NONRENEWAL ENDT
KY	WC160602	(10/99)	KY NOTICE OF APPEAL RIGHTS
KY	WC990403	(7/11)	INSTALLMENT FEE
LA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
LA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
LA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
LA	WC000419	(1/01)	PREMIUM DUE DATE ENDT
LA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
LA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
LA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
LA	WC170303	(12/00)	DUTY TO DEFEND ENDT
LA	WC170601J	(8/18)	LA AMENDATORY ENDORSEMENT
LA	WC170602A	(2/96)	COST CONTAINMENT ACT
LA	WC990403	(7/11)	INSTALLMENT FEE

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
MI	WC210303A	(6/97)	MI NOTICE TO POLICYHOLDER ENDT
MI	WC210304	(4/84)	MI LAW ENDORSEMENT
MI	WC990403	(7/11)	INSTALLMENT FEE
MI	WC990655	(1/14)	MICHIGAN DISCLAIMER
MO	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MO	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MO	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
MO	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MO	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MO	WC240302	(1/14)	ADD'L MESOTHELIOMA BENEFITS
MO	WC240601B	(1/96)	MO CANC/NRN ENDT
MO	WC240602B	(7/06)	MO PROP & CAS GUARANTY ASSOC
MO	WC240604C	(9/19)	MISSOURI AMENDATORY END
MO	WC990403	(7/11)	INSTALLMENT FEE
MT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MT	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MT	WC000419	(1/01)	PREMIUM DUE DATE ENDT
MT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
MT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MT	WC250305	(7/02)	INTENTIONAL INJURY EXCL
MT	WC250401A	(1/17)	MONTANA AUDIT NONCOMPLIANCE
MT	WC250601B	(4/16)	MT AMENDATORY ENDORSEMENT
MT	WC250602	(1/94)	SAFETY ENDT
MT	WC990403	(7/11)	INSTALLMENT FEE
NE	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NE	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NE	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NE	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NE	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NE	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NE	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NE	WC260401B	(5/17)	NE EXP RATING MOD FACTOR

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NE	WC260403	(5/17)	NE EXP RATING MOD FACTOR REV
NE	WC260601C	(7/96)	NE CANCELLATION ENDT
NE	WC990403	(7/11)	INSTALLMENT FEE
NV	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NV	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NV	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NV	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NV	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NV	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NV	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NV	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NV	WC270601C	(10/08)	NV CANCELATION/NONRENEWAL ENDT
NV	WC990403	(7/11)	INSTALLMENT FEE
NM	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NM	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NM	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NM	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NM	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NM	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NM	WC300601A	(3/15)	NM CANC AND NONRENEWAL ENDT
NM	WC990403	(7/11)	INSTALLMENT FEE
NC	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NC	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NC	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NC	WC000419	(1/01)	PREMIUM DUE DATE ENDT
NC	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NC	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NC	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NC	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NC	WC320301D	(7/18)	NC AMENDED COVERAGE ENDT
NC	WC320602	(1/10)	PRO-RATA CANCEL ENDT
NC	WC990403	(7/11)	INSTALLMENT FEE
OK	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
OK	WC000404	(4/84)	PENDING RATE CHANGE ENDT
OK	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
OK	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
OK	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
OK	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT

* Indicates that this endorsement is added or modified.

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
OK	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
OK	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
OK	WC350302	(1/87)	OK EMPL LIABILITY AMENDED COV
OK	WC350303	(3/11)	OK EL INTENTIONAL TORT EXCL
OK	WC350601F	(2/14)	OK CN,NONRENEWAL & CHG ENDT
OK	WC350603	(12/93)	OK FRAUD WARNING ENDT
OK	WC990407	(7/14)	INSTALLMENT FEE
OR	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
OR	WC000404	(4/84)	PENDING RATE CHANGE ENDT
OR	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
OR	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
OR	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
OR	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
OR	WC360404A	(5/17)	OR GROUP SUPPLEMNT RTG END
OR	WC360406	(10/01)	OR PREMIUM DUE DATE ENDMNT
OR	WC360601E	(1/08)	OR CANCELLATION ENDMNT
OR	WC360604	(1/17)	OR AMENDATORY ENDORSEMENT
OR	WC990403	(7/11)	INSTALLMENT FEE
SD	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
SD	WC000404	(4/84)	PENDING RATE CHANGE ENDT
SD	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
SD	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
SD	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
SD	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
SD	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
SD	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
SD	WC400601A	(7/11)	SD DIRECT ACTION STATUTE
SD	WC400603	(1/94)	SD MANAGED CARE ENDMNT
SD	WC400605B	(4/06)	SD CANCELLATION AND NONRENEW
SD	WC990403	(7/11)	INSTALLMENT FEE
TX	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
TX	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
TX	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
TX	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
TX	WC420301J	(6/20)	TEXAS AMENDATORY ENDORSEMENT
TX	WC420407	(3/02)	TX AUDIT PREMIUM & RETROSPECT
UT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
UT	WC000404	(4/84)	PENDING RATE CHANGE ENDT

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
UT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
UT	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
UT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
UT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
UT	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
UT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
UT	WC430602	(7/02)	UT CANCELLATION ENDORSEMENT
UT	WC990403	(7/11)	INSTALLMENT FEE
WI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
WI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
WI	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
WI	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
WI	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
WI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
WI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
WI	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
WI	WC480601C	(4/01)	WI LAW ENDT
WI	WC480606B	(1/02)	WI CANC/NRN ENDT
HI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
HI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
HI	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
HI	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
HI	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
HI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
HI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
HI	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
HI	WC520602	(1/96)	HI NOTIFICATION ENDT
HI	WC990403	(7/11)	INSTALLMENT FEE
AK	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AK	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AK	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AK	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
AK	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AK	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AK	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AK	WC540301	(4/95)	AK LIMIT OF LIABILITY ENDT
AK	WC540601A	(1/13)	AK NOTICE OF INSTALLMENT OP
AK	WC540602	(4/95)	AK CANCEL/NONRENEWAL ENDT

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
AK	WC990643	(1/13)	AK PAYMENT PLANS ENDT

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

POLICY NUMBER: 310 2805098

1. Named Insured and Address	Agent – For Informational Purposes Only
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier Code #	FEIN #:	Risk ID #	Type of Insured: ___ Individual ___ Partnership X Corporation or ______
38563	016000769	SEE EXT OF INFO	

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address

3. A. Workers Compensation Insurance: PART ONE of the policy applies to the Workers Compensation Law of the states listed here: FL

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

C. Other States Insurance: PART THREE of the policy applies to the states, if any, listed here.
AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

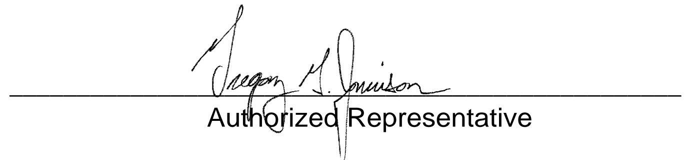
SEE EXTENSION OF INFORMATION PAGE FOR MORE DETAIL

Florida Workers Compensation Insurance Guaranty Association Surcharge: 1.0 %

Minimum Premium $ 315

Total Estimated Annual Premium $ 4,388
Expense Constant $ 220
Deposit Premium N/A in Florida

Countersigned this day of
Issued Date: 10/28/2020
Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551



Authorized Representative

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 4
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
FLORIDA					
LOC: 00006 ADDRESS: 177 JONES CREEK DRIVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	138,520.00	0.440000	$	609
	MANUAL PREMIUM			**$**	**609**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	609.00	0.014000	$	9
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	618.00	0.680000	$	-198
9740	TERRORISM	138,520.00	0.010000	$	14
FWCIGA	FL WC GUARANTY ASSOC SURCHARGE	434.00	0.010000	$	4
	STATE TOTAL			**$**	**438**

Issued Date: 10/28/2020
WC 00 00 01 A (Ed. 2-19)

EXTENSION OF INFORMATION PAGE FOR ITEM 1
ADDITIONAL WORKPLACES SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00006	UNIVERSITY OF MAINE SYSTEM	177 JONES CREEK DRIVE JUPITER FL 30201-0000	
00029	UNIVERSITY OF MAINE SYSTEM	14317 LUCERNE DRIVE #G TAMPA FL 30201-0000	

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number:	310 2805098	
Named Insured:	UNIVERSITY OF MAINE SYSTEM	
Agent:	CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 1

NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM	CORPORATION	016000769

Issued Date: 10/28/2020

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 3 D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
FL	WC000404	(4/84)	PENDING RATE CHANGE ENDT
FL	WC000406A	(7/95)	PREMIUM DISCOUNT ENDORSEMENT
FL	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
FL	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
FL	WC090303	(8/05)	FL EMPLOYERS LIAB COV ENDT
FL	WC090402A	(5/17)	FL EXP RATING MOD FACTOR
FL	WC090403B	(1/15)	TERRORISM RISK INS ACT ENDT
FL	WC090407	(7/13)	FL NON-COOP WITH PREMIUM AUDIT
FL	WC090408A	(7/19)	FLORIDA INSUFFICIENT FUNDS EN
FL	WC090606	(10/98)	FL EMPL & WAGE INFO RELEASE
FL	WC090607A	(7/19)	FL WC GUARANTY ASSOC SURCHARGE
FL	WC990678	(5/18)	EXECUTION CLAUSE

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance

POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
310 2805098	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	
Prior Policy Number	Renewal of 310 2805098	

Transaction - AMENDED DECLARATION

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000
Email address:	Telephone: 207-947-7345

NCCI Carrier #	FEIN #:	Intra/Interstate Risk ID#	Entity of Insured
38563	016000769	SEE EXT OF INFO	___ Individual ___ Partnership X Corporation ___ LLC ___ LLP or Other___

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: CA

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

   Bodily Injury by Accident $1,000,000 Each accident
   Bodily Injury by Disease $1,000,000 Policy limit
   Bodily Injury by Disease $1,000,000 Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here.
   AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE.

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

SEE EXTENSION OF INFORMATION PAGE

Minimum Premium	$	315
Experience Modification Factor		0.0
Assessments and Taxes	$	62
Total Estimated Annual Premium	$	4,388
Expense Constant	$	220
Deposit Premium	$	4,388

Countersigned this day of

Issued Date: 10/28/2020

Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551

Authorized Representative

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
CALIFORNIA					
LOC: 00031 ADDRESS: 811 LARKRIDGE STREET PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	103,317.00	1.020000	$	1,054
	MANUAL PREMIUM			**$**	**1,054**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	1,054.00	0.011000	$	12
9740	TERRORISM	103,317.00	0.031000	$	32
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	103,317.00	0.020000	$	21
CA AST	CALIFORNIA WORKERS COMPENSATION FRAUD ASSESSMENT FACTOR	1,119.00	0.003349	$	4
CA LEC	CA-LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT	1,119.00	0.003813	$	4
CA OSH	CA OCCUPATIONAL SAFETY & HEALTH FUND	1,119.00	0.003918	$	4
CA SIB	CALIFORNIA SUBSEQUENT INJURIES BENEFIT TRUST FUND ASSESSMENT	1,119.00	0.004829	$	5
CA SRG	CA WC ADMINISTRATION REVOLVING FUND ASSESSMENT	1,119.00	0.017040	$	19
CA UEB	CALIFORNIA UNINSURED EMPLOYERS BENEFIT TRUST FUND ASSESSMENT	1,119.00	0.001274	$	1
CIGAS	CALIFORNIA INSURANCE GUARANTEE ASSOCIATION SURCHARGE	1,119.00	0.000000	$	0
	STATE TOTAL			**$**	**1,156**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM ONE
ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00031	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	811 LARKRIDGE STREET IRVINE CA 94201	
00032	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	11365 LAKE RIM ROAD SAN DIEGO CA 93201	
00033	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	345 MIDDLEFIELD ROAD MENLO PARK CA 94201	

Issued Date: 10/28/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM ONE
NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	CORPORATION	016000769

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
CA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
CA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
CA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
CA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
CA	WC040301D	(2/18)	POLICY AMENDATORY ENDT - CA
CA	WC040310	(1/95)	CA DUTY TO DEFEND
CA	WC040360B	(1/15)	CA EMPLOYERS LIAB COV ENDT
CA	WC040421	(1/08)	CA OPTIONAL PREMIUM INCREASE
CA	WC040422	(1/12)	CA SHORT RATE CANCELLATION
CA	WC040601A	(12/93)	CA CANCELLATION ENDT
CA	WC990403	(7/11)	INSTALLMENT FEE

* Indicates that this endorsement is added or modified.

Issued Date: 10/28/2020

Arizona Cancellation and Nonrenewal Endorsement

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

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

D. **Cancellation and Nonrenewal**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. If you cancel or fail to renew this policy, we must promptly notify the Industrial Commission of Arizona.
3. We may cancel this policy if you fail to pay premium when due, or when one or both of the parties to a professional employer agreement terminate the agreement.
   - If we cancel or nonrenew this policy, we must provide to you and the Industrial Commission of Arizona at least 30 days' notice of the cancellation or nonrenewal. Notice may be sent via mail or email as follows:
     - Mailing that notice to you at your last-known mailing address on file with us will be sufficient proof of notice.
     - If you consented to have the notice emailed in accordance with Arizona law, emailing that notice to you at your last-known email address as provided by you to us will be sufficient proof of notice.
       - If the email notice is: (1) rejected for delivery; (2) returned to us; or (3) we become aware that the email address provided by you is no longer valid, then we will also mail that notice to you by US Postal Service certified mail, certificate of mailing, or first-class mail using intelligent mail barcode, or another similar tracking method used or approved by the US Postal Service.
   - If we nonrenew this policy and fail to give you notice of nonrenewal, coverage will not extend beyond the policy period.
4. The policy period will end on the date and time stated in the cancellation or nonrenewal notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

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

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

Endorsement Effective 10/01/2020 Policy No. 310 2805098 Endorsement No. 001
Insured UNIVERSITY OF MAINE SYSTEM Premium $4,388.00

Insurance Company MEMIC Indemnity-Standard Countersigned by ____________________

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MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

UNIVERSITY OF MAINE SYSTEM
UNIVERSITY SERVICES: RISK MGT
46 UNIVERSITY DR
ROBINSON HALL
AUGUSTA ME 04330

NAMED INSURED: UNIVERSITY OF MAINE SYSTEM
POLICY NUMBER: 310 2805098
EFFECTIVE DATE: 10/01/2020
AGENCY NAME: CROSS INSURANCE - BANGOR

WELCOME

Thank you for choosing MEMIC Indemnity Company for your workers' compensation coverage!

POSTING NOTICES

Please note that your POSTING NOTICES are enclosed with this policy package.
Please be sure to post these notices at the worksite as required by your jurisdiction(s).

SERVICES

We urge you to go to our website at www.memic.com to review our extensive on-line information for employers. Building a solid safety plan is not easy - but MEMIC's Online Safety Director program can help. Start today and gain access to MEMIC's electronic resource library and/or complete an online safety assessment of your organization. You can also pay your bill on-line, sign up for electronic billing, report an injury, view our safety training seminar schedules and more.

CONTACT US

Mailing address: PO Box 11409, Portland, ME 04104
Toll Free: 800-660-1306
Report a Claim: 866-636-4292 or www.memic.com
Fax: Underwriting 207-791-3335 - Claims: 207-791-3334

YOUR POLICY

Please review your policy carefully, as it describes and defines your coverage. Please contact your insurance agent with any questions regarding your policy.

THANK YOU

We look forward to working with you!

the claims process

follow these best practices

1. Send injured worker to your healthcare provider
If you've made arrangements with a healthcare provider in MEMIC's network (see list at memic.com), you can send your employee to them. (Some states allow the employer to choose the doctor. Contact your claim specialist or state workers' compensation agency to learn about your state's requirements.) Call your provider to alert them about your injured employee and give a brief description of their job.

2. Accompany injured worker to hospital
You or a supervisor must get involved from the moment an injury is reported. Tell the employee and the doctor of your desire to be involved in the worker's recovery and their return to work.

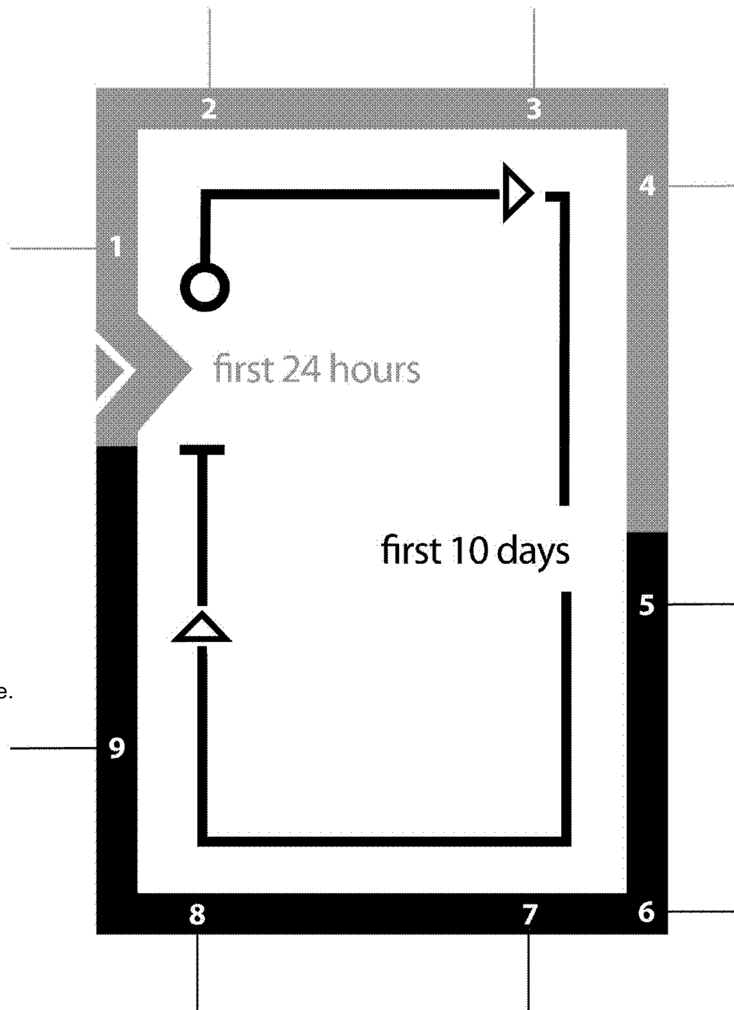
3. Gather the facts
The main objective is to report the claim quickly and completely. Gather as much information as possible before reporting a claim, but don't delay in reporting if you are missing a piece of information. Any missing information will be gathered by the claim specialist as the claim is handled.

4. Report injury to MEMIC promptly
All claims should be reported to MEMIC within 24 hours of your notice or knowledge of the injury. (In fact, in some states you must report a workplace injury within 48 hours of knowledge of the injury.) An average report takes less than 8 minutes. We recommend reporting online or by phone.

REPORT INJURY 1 OF 4 WAYS

1. Online at **memic.com**
2. Call it in to **1.800.636.4292**
3. Fax form* to **207.791.3334**
4. Mail form* to **MEMIC Claim Dept., PO Box 3606, Portland, ME 04104**

**Contact your state workers' compensation agency for form.*



5. Keep us informed
As your partner in helping your employee back to work, we rely on you for information. It is important that you communicate any status changes or additional information that will assist us in the proper and efficient handling of your claim. Also, if you report a claim as having no lost-time and the injured worker later loses the equivalent of a day, please notify us immediately.

6. Stay involved
Talk with the injured person about their condition, their work capacity and your desire to have them back at work. Open communication helps all involved.

7. Identify return-to-work options
Work with your employee and the doctor to find "light" or alternative duties that will aid in getting them back to work as soon as appropriate. Prepare a written plan for their return-to-work and share it with the employee, healthcare provider, supervisor and MEMIC claim specialist.

8. Practice full disclosure
Inform your employee of their rights and benefits under the workers' compensation system and encourage them to contact our claim department if they need additional assistance. Good information avoids conflict.

9. Follow procedures
If your employee is eligible to receive wage replacement benefits, submit a Wage Statement as soon as possible. Some states have waiting limits. Contact your claim specialist or state workers' compensation agency to learn more about your responsibilites.

MEMIC

workers' comp at-a-glance

your guide to working with MEMIC

Claim Reporting

Choose 1 of 3 ways to report an injury.

We recommend reporting online or by phone.

Online

Go to memic.com and select "Report an Injury" from the "FOR EMPLOYERS" menu.

By Phone

- Call 1-800-MEMICWC or 1-800-636-4292
- Fax to 207-791-3334

By Mail

MEMIC Claim Department
PO Box 3606
Portland, ME 04104

Contact your state's workers' compensation agency for form.

WHEN TO REPORT

All claims should be reported to MEMIC within 24 hours of your notice or knowledge of the injury. *Do not delay because you are missing a piece of information!*

WHAT YOU NEED TO REPORT

Gather as much information as you can about the accident and injury. You'll also need: your MEMIC policy number, injured employee's name, date of injury and the date you were notified.

FIND A MEDICAL PROVIDER

Some states allow you to choose the doctor who initially treats your injured worker. If this is the case for your state, choosing a medical provider and building a relationship with them before an injury happens should be your first order of business. This often helps your medical provider understand the nature of your work and, in turn, speeds recovery.

MEMIC has a network of medical providers who are especially attuned to the needs of workplace injuries.

MEMIC's Online Provider Search

Search for doctors closest to an address, by name or phone number, by geographical region or through a quick search with pre-selected doctor type and distance. View results on Google Maps and easily print or text driving directions to your mobile phone.

Go to memic.com > Click "FOR EMPLOYERS" > Select "Find a Medical Provider"

Contacting MEMIC

Policy support

For billing, premium audit, workplace safety or claims inquiries call us Monday through Friday between 8:00 a.m. and 4:30 p.m. EST.

1-800-660-1306

Online Inquiry

Use the online inquiry form to quickly submit a general inquiry, ask about a claim, report fraud, get safety advice or send us feedback about our website.

Go to memic.com > Select "Contact Us"

Safety Inquiries?

Email your safety questions to our in-house safety experts.

Email losscontrolservices@memic.com

On the Web

memic.com

Our website is full of information to help you build a better business and manage your claims. From the website, you can also take a video tour of our online reporting form and watch a video to learn the ins and outs of filing a claim and why choosing a medical provider should be at the top of your list.

Go to memic.com > Select "FOR EMPLOYERS"

MEMIC Safety Director

Building a solid safety plan is not easy, but MEMIC's Online Safety Director can help. Start today and gain access to MEMIC's electronic resource library and/or complete an online safety assessment of your organization.

Go to memic.com > Select "Log in to Safety Director"

Safety Net Blog

Subscribe to our regular blog about all topics related to workplace safety. Join in the conversation with MEMIC safety experts about current issues or ideas.

Go to memicsafety.typepad.com

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

MEMIC Indemnity Company
Insurer

650 Elm St Suite 401
Street and Number

Manchester NH 03101-2551	NH	03101-2551
City	State	Zip Code

For the period from 10/01/2020 Through 10/01/2021

MEMIC Indemnity Company
Adjusting Company

650 Elm Street Suite 401
Street and Number

Manchester	NH	03101-2551	800-636-4292
City	State	Zip Code	Telephone

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

UNIVERSITY OF MAINE SYSTEM
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 Ave	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.

TO BE POSTED BY EMPLOYER **POLICY NUMBER** 310 2805098

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

MEMIC Indemnity Company

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that blanks and forms for such notice are available to all employees at the office of this employer.

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

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSACION DE OBREROS DE ARIZONA

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

MEMIC Indemnity Company

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

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

KEEP POSTED IN A CONSPICUOUS PLACE

TO BE POSTED BY EMPLOYER

POLICY NUMBER 310 2805098

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

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MEMIC Indemnity Company

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

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

KEEP POSTED IN A CONSPICUOUS PLACE

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (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) 628-5181. 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 SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the 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 IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

WORK EXPOSURE TO BODILY FLUIDS

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KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE IS APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

Se les notifica a los empleados que se puede hacer una reclamación por una condición, infección, enfermedad o incapacidad relacionada con o derivada del Virus de Inmunodeficiencia Humana (VIH), Síndrome 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 incluír 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) quirúrgico(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 uso ilícito de drogas.

Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen 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) quirúrgico(s) o cualquier otro fluido que contenga sangre. Incluídos en esta categoría son los proveedores de cuidados de la salud, trabajadores de laboratorios forenses, bomberos, agentes policiales, técnicos médicos de emergencia, paramédicos y agentes correccionales.

2. **NO MAS DE DIEZ (10) DIAS DE CALENDARIO** después de una possible exposición importante que resulta de y en el curso de su trabajo, el empleado reporta a su patrón 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 patrón o de la Comisión Industrial de Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 o 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5181. 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 exposción 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 VIH, o **NO MAS DE SIETE (7) MESES** después de la fecha de la posible exposición importante en el trabajo, el empleado es examinado nuevamente y los resultados del análisis son positivos por la presencia de Hepatitis C o el empleado ha sido diagnosticado como positivo por la presencia de Hepatitis C.

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

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

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

ICA FORM 04-615-01

EXPOSICION A FLUIDOS CORPORALES EN EL TRABAJO

AVISO A LOS EMPLEADOS

Re: El Virus de la Inmunodeficiencia Humana (VIH),
Síndrome de la Inmundeficiencia Adquirida (SIDA) y Hepatitis C

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Ciertas clases de empleados pueden establecer más fácilmente una reclamación relacionada con el VIH, SIDA O Hepatitis C si reúnen los requisitos siguientes:

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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

Este documento es una traduccion del texto original escrito en ingles. Esta traduccion no es oficial y no es vinculante para este estado o para una subdivision politica de este estado.

This document is a translation from original text written in English. This translation is unofficial and is not binding on this state or a political subdivision of this state.

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.

REV 7/11

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REV 7/11

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail:P.O. Box 950, Little Rock, AR 72203-0950 Little Rock Office - 1-800-622-4472 / 501-682-3930 Springdale Office - 1-800-852-5376 / 479-751-2790	P
Ark. Code Ann. §11-9-403,407 AWCC Rule7 Updated: 06-16-14		

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551
1-800-MEMIC-WC
10/01/2021

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann.§11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and

(2) The employer refuses to refer the employee to medical provider within forty-eight (48) hours after such written request as provided above; and

(3) The alleged injury is later found to be a compensable injury; and

(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P
(Posting Notice)

A posting notice is mentioned in **Ark. Code Ann. §11-9-403, Ark. Code Ann. §11-9-407** and **AWCC Rule 7. AWCC Form P** satisfies all requirements.

Form P:

1. Is to be on display in a conspicuous place;

2. Tells employers what to do when an employee is injured;

3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;

4. Lists the claims office that will be handling the insurance aspects of the case;

5. Gives the claims office telephone number;

6. Announces the expiration date of the insurance policy; and

7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P.** Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about Form P is available from the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106 (a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under.... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Formulario AR-P	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS 324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 Oficina de Little Rock: 1-800-622-4472 / 501-682-3930 Oficina de Springdale: 1-800-852-5376 / 479-751-2790	P
Autoridad: Ark. Code Ann., apartado 11-9-403, 407 AWCC, Norma 7 Actualizado: 06-16-2014 En Español: 10-15-2004		

INSTRUCCIONES SOBRE LA COMPENSACIÓN DE LOS TRABAJADORES PARA EMPLEADORES Y EMPLEADOS

Todo los empleados de este centro que tengan derecho a beneficiales en virtud de lo dispuesto en la legislación de compensación de los trabajadores son informados en virtud del presente documento de que su empleador ha organizado el pago de las compensaciones que puedan tener que abonarse a los empleados o sus dependientes. Este empleador debe, en virtud de la legislación estatal, ofrecer a sus empleados cobertura por compensaciones o harenunciado a la exención o exclusión de la ejecución de la legislación en materia de compensaciones a los trabajadores y certifica mediante la muestra de este cartel que en la actualidad ofrecer cobertura a sus trabajadores dentro de una póliza de seguro de compensación de los trabajadores o por su participación en el Programa de Auto-seguros de Arkansas o la División Pública de Reclamaciones de los Empleados del Departamento de Seguros de Arkansas.

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551
1-800-MEMIC-WC
10/01/2021

EN CASO DE PRODUCIRSE UNA LESIÓN VINCULADA AL TRABAJO O UNA ENFERMEDAD PROFESIONAL

El empleador deberá:

1. Ofrecer todo el tratamiento médico, quirúrgico y hospitalario que sea preciso en virtud de la legislación, tras la lesión y durante el tiempo adicional que establezca la Comisión de Compensación de los trabajadores.
2. Ofrecer pagos de compensación de acuerdo con lo dispuesto en la legislación. El primer plazo vencerá al cabo de 15 dias desde que el empleador sea informado de la lesión o fallecimiento, excepto en los casos en el empleador haya denegado su responsabilidad.
3. Informar inmediatamente de los accidentes a los interesados.
4. Mantener un registro de todas las lesiones de las que sea informado por sus empleados.

El empleado deberá:

El empleado deberá informar de la lesión al empleador en el formulario N y a una persona o en un lugar indicado por este último, a menos que se trate de una lesión que impida mental o fisicamente al empleado hacerlo o si la lesión se comunica al empleador inmediatamente después de producirse. El empleador no será responsable de las beneficiales de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente. Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación. Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.

La falta de notificación no anulará las reclamaciones si: (1) El empleador tiene conocimiento del fallecimiento o lesión; o (2) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o (3) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justifcado.

Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

Información legal:

El articulo 11-9-514(b) del Ark. Code Ann. establece que: "El tratamiento o los servicios prestados por un médico distinto de los seleccionados de acuerdo con lo anterior, con excepción de los tratamientos urgentes, correrán a cargo del demandante."
El artículo 11-9-514(f) del Ark. Code Ann., sin embargo, establece que: Cuando la compensación sea causa de controversia, el subapartado (b) no será de aplicación si:
(1) El empleado solicita asistencia médica por escrito antes de buscarla como consecuencia de una posible lesión compensable; y
(2) El empleador se niega a remitir al empleado a un proveedor médico en el plazo de cuarenta y ocho (48) horas desde dicha solicitud escrita; y
(3) Posteriormente se descubre que la supuesta lesión es compensable; y
(4) El empleador no ha hecho ninguna oferta anterior de tratamiento médico.

Si tiene alguna pregunta relativa a sus derechos en virtud de la legislación en materia de compensaciones de los trabajadores de Arkansas, puede llamar al asesor legal de la Comisión de Compensación de los Trabajadores de Arkansas al número gratuito que se indica más arriba.

Todos los empleadores que se vean afectados por la ejecución de la legislación en materia de compensaciones de los trabajadores de Arkansas y que hayan cumplido estas disposiciones deberán colocar esta notificación en un lugar **PREEMINENTE** en su centro de trabajo o las cercanias.

Formulario P de la AWCC
(Notificación)

En los **apartados 11-9-403 y 11-9-407 del Ark. Code Ann. y la Regla 7 de la AWCC** se menciona una notificación. El **formulario P de la AWWC** cumple todos esos requisitos.

Formulario P:

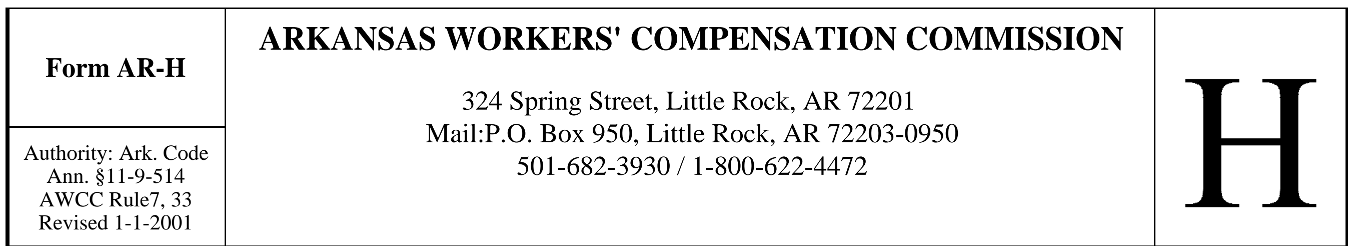
1. Debe mostrarse en un lugar preeminente;
2. Dice a los empleados qué deben hacer cuando un trabajador se lesiona;
3. Instruye a los empleados para que notifiquen las lesiones inmediatamente al empleador (o no más tarde del final del siguiente día laborable);
4. Enumera la oficina de reclamaciones en la que se tratarán los aspectos vinculados a seguros del caso;
5. Anuncia la fecha en que expira la póliza de seguros;
6. Ofrece números de teléfono del asesor legal de la Comisión de Compensaciones de los Trabajadores de Arkansas por si alguien necesita ayuda.

Los empleadores que no cuenten con un **formulario P** podrán perder el derecho a utilizar el **formulario N** como defensa en un litigio. Los empleados que desobedezcan las instrucciones del **formulario P** podrán sufrir retrasos en el beneficio de cualquier prestación en los casos que se impugnen o corren el riesgo de perderlos.

La AWCC ofrece copias de muestra pero no suministra el **formulario P.** Las aseguradoras deben enviar a sus asegurados un número adecuado de copias y los auto-asegurados deben contratar el suministro con una imprenta. Las aseguradoras y los empleadores pueden ampliar el **formulario P** para publicarlo.

Puede obtenerse información sobre el formulario P de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106 (a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de beneficiales o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este articulo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Fallecimiento administrado por la Comisión de Compensaciones de los Trabajadores."


Form AR-H

Authority: Ark. Code Ann. §11-9-514 AWCC Rule7, 33 Revised 1-1-2001

ARKANSAS WORKERS' COMPENSATION COMMISSION

324 Spring Street, Little Rock, AR 72201
Mail:P.O. Box 950, Little Rock, AR 72203-0950
501-682-3930 / 1-800-622-4472

H

HEALTH CARE NOTICE FOR EMPLOYEES UNDER MANAGED CARE

Your employer has contracted with the following **M**anaged **C**are **O**rganization (**MCO**):

Name CorVel Corporation

Address 10800 Financial Center Parkway, Suite 485 Little Rock, AR 72211

or has been certified as an **I**nternal **M**anaged **C**are **S**ystem (**IMCS**). ***You are required to receive treatment through this MCO/IMCS if you receive a work-related injury. If you do not receive treatment through this MCO/IMCS, or you do not obtain permission to change treatment provider(s), then you may be required to pay for the treatment you receive***. Emergency treatment is exempt from this requirement.

Employees are covered under the MCO/IMCS ***after*** the employer posts Form H. Prior notice given to employees by a certified MCO shall fulfill the above notice requirements.

The telephone number of your employer's MCO/IMCS is 501-255-6200. You may call this number if you have questions about managed care or if you need names of physicians.

If you are injured on the job, you should notify your supervisor immediately. Your supervisor will arrange for treatment or explain what you need to do to receive treatment for your injury.

If you have a problem with or a dispute about this MCO/IMCS, you may file a complaint within thirty (30) days of the occurrence. To obtain information contact your supervisor, the MCO/IMCS, or the Medical Cost Containment Division at the AWCC (1-800-622-4472 or 501-682-3930).

If you are balance billed by a physician for a covered workers' compensation injury, you should notify your employer. Balance billing occurs when physicians are paid according to the MCO/IMCS contract or the Arkansas Workers' Compensation Fee Schedule, the amount they were paid is less than the amount of their bill, and they attempt to collect the difference from employees.

Choice/change of physician is controlled by law. Your employer may choose the initial treating physician. Any referral would be to parties abiding by MCO rules, terms, and conditions. Emergency medical treatment is exempted. If you want a change of physician, request it from the insurance carrier or employer. If the decision is unsatisfactory, you may petition the Commission for a change. "[T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission." Ark. Code Ann. § 11-9-508(e) ***Treatment or services furnished or prescribed other than according to the above, EXCEPT EMERGENCY TREATMENT, shall be at your own expense.***

H

AWCC Form H

(Health Notice for Managed Care)

AWCC Rule 33 (Managed Care) requires employers under a Managed Care program to have posted in the workplace a notice of the Managed Care Organization (MCO) or Internal Managed Care System (IMCS).

Form H, effective 1-1-2001, satisfies the requirements of revised Rule 33, effective 11-15-1999.

Help with Form H is available from the Medical Cost Containment Division. General information is available from the Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106 (a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under.... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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 visists.
- **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 now 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 you employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: ______

MPN Effective Date: ______ MPN Identification number: ______

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

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 ______ Phone ______

Workers' compensation insurer MEMIC Indemnity Company (Enter "self-insured" is 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.

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

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- **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.
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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 you employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: ______________________

MPN Effective Date: ______________ MPN Identification number: ______________

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

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 ______________ Phone ______________

Workers' compensation insurer MEMIC Indemnity Company (Enter "self-insured" is 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.

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 visists.
- **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 now 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 you employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: ______________________________

MPN Effective Date: ______________ MPN Identification number: ______________

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

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 ______________________ Phone ______________

Workers' compensation insurer MEMIC Indemnity Company (Enter "self-insured" is 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."

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Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas 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 mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si 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 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 or 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 lesión, 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 información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratmiento 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 requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguente información del contacto de la MPN:

Página web de la MPN: ____________________

Fecha de vigencia de la MPN: ____________ Número de identificación de la MPN: ____________

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: ____________

Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: ____________

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

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

Administrador de Reclamos ____________ Teléfono ____________

Asegurador del Seguro de Compensación de trabajador MEMIC Indemnity Company (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 Trabajdores. 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 representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas 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 mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si 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 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 or 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 lesión, 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 información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratmiento 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 requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguente información del contacto de la MPN:

Página web de la MPN: ____________________

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Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: ____________

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

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

Administrador de Reclamos ____________________ Teléfono ____________

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Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

ESTADO DE CALIFORNIA - DEPARTAMENTO DE RELACIONES INDUSTRIALES
División de Compensación de Trabajadores

Aviso a los Empleados—Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una caída) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación para trabajadores incluyen:

- **Atención Médica:** Consultas 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 mayoría de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si 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.
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- **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 or departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
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   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médica que proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si está cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. Red de Proveedores Médicos (MPN): Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratmiento 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 requerirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguente información del contacto de la MPN:

Página web de la MPN: ____________________

Fecha de vigencia de la MPN: ____________ Número de identificación de la MPN: ____________

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: ____________

Si usted tiene preguntas sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al: ____________

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecido por el estado.

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

Administrador de Reclamos ____________ Teléfono ____________

Asegurador del Seguro de Compensación de trabajador MEMIC Indemnity Company (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 Trabajdores. 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 representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensación de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene de su participación voluntaria en cualquier **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:

MEMIC Indemnity Company

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

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

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

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

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

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

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

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

Información De Indemnización Por Accidentes Laborales De Colorado

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

MEMIC Indemnity Company

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

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

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

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

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

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

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

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 your inability to work is properly certified by a physician. Generally, you must have worked for an employer in Hawaii at least two weeks prior to 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 health care plan must be approved by the Department 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.

Scott T. Murakami, 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.

Revised 5/30/19

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 $675 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 $675 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 $450 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 $450 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 $675 per week. A widowed spouse with no children will be paid a maximum of $270,000. 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: http://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 1-800-237-2629.

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 $675 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 $675 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 $450 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 $450 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 $675 por semana. Una esposa viuda sin niños se le pagara un máximo de $270,000 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: http://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 1-800-237-2629.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 O 1-800-533-0682 O VISITA SITIO WEB: http://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).

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 DEPENDENT'S, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

UNIVERSITY OF MAINE SYSTEM
Employer

____
Date

By ______________________________
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her Supervisor, superintendent, or the undersigned, who will provide medical attendance. Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

1-800-636-4292

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

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

AVISO

RESPECTO EL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADOS POR EL SUSCRITO SON, POR LA PRESENTE, NOTIFICADOS QUE EL PATRÓN HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTED, DE CUERDO CON LAS PROVISIONES DE LA LEY DE COMPENSACIÓN PARA TRABAJODORES.

UNIVERSITY OF MAINE SYSTEM
Patrón

____
Fecha

By ______________________________
Agente Autorizado del Patrón

Un empleado que recibe un dano en accidente tiene que notificar immediatemente a su mayordomo o mayordoma superintendente o a la persona suscrita , quien proveera atención médica.

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

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

1-800-636-4292

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

WORKER'S COMPENSATION NOTICE

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

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

The worker's compensation insurance carrier or the administrator for

UNIVERSITY OF MAINE SYSTEM **is:** MEMIC Indemnity Company

(name of company) **(name of insurance carrier or administrator)**

MEMIC Indemnity Company

(name of insurance carrier/administrator)

650 Elm Street Suite 401

(mailing address)

Manchester NH 03101-2551

(city, state, zip)

1-800-MEMIC WC

(telephone number)

Executive Underwriter

(contact person)

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

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

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

UNIVERSITY OF MAINE SYSTEM **es:**

(nombre de la compañía)

MEMIC Indemnity Company

(nombre de la compañía de seguro/administrador)

650 Elm Street Suite 401

(dirección)

Manchester NH 03101-2551

(ciudad, estado, código postal)

1-800-MEMIC WC

(número de teléfono)

Executive Underwriter

(persona de contacto)

Para mas información acerca de sus derechos o los procedimientos bajo el sistema de compensación para trabajadores de Indiana, llame o escriba a:

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

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: UNIVERSITY OF MAINE SYSTEM
Address: 3840 NADIA LANE LEXINGTON KY 40514-0000
Workers Compensation Carrier: MEMIC Indemnity Company
(or third party administrator):
Policy #: 310 2805098 04 **, effective** 10/01/2020 **to** 10/01/2021
Address: 650 Elm Street Suite 401 Manchester NH 03101-2551
Telephone: 1-800-MEMIC WC **, Contact Person:** CLAIMS DEPARTMENT

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) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim 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.

04/09/09

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

MEMIC Indemnity Company

650 Elm Street Suite 401

Manchester NH 03101-2551

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

UNIVERSITY OF MAINE SYSTEM

408 KEES CIRCLE

LAFAYETTE LA 70501-0000

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

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene rezones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparace en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

La notificación deberá ser dada ya sea llevάandola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

Empleador

UNIVERSITY OF MAINE SYSTEM
408 KEES CIRCLE
LAFAYETTE LA 70501-0000

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003

www.laworks.net

Un Progama de Igual Oportunidad de Trabajo. Servicios auxiliaries están habilitados si usted lo solicita para personas o individuos con incapacidades. 1-800-259-5154 (TDD)

State of Michigan
Workers' 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' 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

____
Employer Name

____
Employer Contact Person and Telephone Number

____
Workers' Compensation Insurance Carrier Name

If you have questions, please call the
State of Michigan Workers' Compensation Agency
Toll-free 1-888-396-5041

Additional information is on the agency's website at www.michigan.gov/wca.

EMPLOYER: PLEASE POST THIS NOTICE FOR YOUR EMPLOYEES TO SEE!

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Workers' Compensation Agency

Rights & Responsibilities

Michigan's workers' compensation system provides wage replacement, medical treatment, and vocational rehabilitation benefits to individuals who are injured while at work. Each party in this system has rights and responsibilities that ensure the successful operation of the process.

EMPLOYEES

- Most workers are covered under workers' compensation from the date of employment.
- **Report all injuries to your supervisor immediately**.
- When injured, you can receive wage loss benefits, medical care, and rehabilitation services.
- A compensable injury is one that has arisen "out of and in the course of employment." The 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 benefit payments.** You will not receive a workers' compensation check for disability lasting less than 7 days. However, medical benefits should be provided from the day of injury. If your wage loss lasts longer than 7 consecutive days, you are entitled to benefits as of the 8th day. If your wage loss continues for 14 days or longer, you are entitled to receive payment for that first week of disability.
- 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. This is your Average Weekly Wage (AWW). Generally you should receive 80% of the after-tax value of your AWW.
- In certain circumstances, the value of discontinued "fringe benefits" such as the cost of health insurance, employer contributions to a pension plan, and vacation and holiday pay may be included in determining the AWW.
- You should be paid your benefit on a weekly basis, and payments should continue as long as you are disabled and are suffering a wage loss.
- 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.
- If you have **more than one job** covered under the Act, the earnings from Michigan employers are added together to calculate the AWW.
- 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.
- **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.
- **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 returning to your job and you are currently receiving workers' compensation benefits, you are entitled to a maximum of 104 weeks of vocational assistance in returning to work. Vocational rehabilitation can help you return to your current job or a new one by identifying interests, skills and abilities, evaluating accommodations, providing job readiness assistance, outlining career objectives, and arranging retraining opportunities. Vocational rehabilitation services create a "win-win" scenario for employers, carriers, and injured employees, especially when utilized as an early intervention tool.

EMPLOYERS

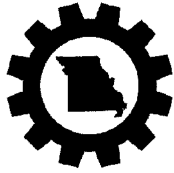
- All public and most private employers in Michigan are covered by workers' compensation. Every employer subject to the Act must provide proof of insurance or be approved for self- insurance to ensure benefits can be paid to its workers should they become injured.
- Eligible employees are covered under workers' compensation from the date of employment.
- There are severe penalties if an employer fails to provide workers' compensation coverage.
- **Minors:** The Act provides that an illegally employed minor is entitled to double compensation if injured.
- **Reporting:**
  - ⇨ All claims must be reported to your insurance carrier.
  - ⇨ Form WC-100: must be filed with the Workers' Compensation Agency 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.
- You are encouraged to maintain contact with your employees while they are off work, and provide appropriate light-duty work options and accommodations when possible.

INSURANCE COMPANIES

- Prompt and regular payment of benefits is required by law.
  - ⇨ Form WC-701: must be filed with the Workers' Compensation Agency (WCA) when wage loss benefits begin, change or stop.
  - ⇨ Form WC-110: must be filed with the WCA 3 months post- injury, and every 4 months after, to report on vocational rehabilitation activity.
  - ⇨ Form WC-107: must be filed with the WCA if a claim is disputed.
- Medical services rendered are subject to the State of Michigan Health Care Rules and Fee Schedules. Injured employees 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, but a hearing can be requested.

For more information contact: State of Michigan - Workers' Compensation Agency
Toll free: 1-888-396-5041 www.michigan.gov/wca

WC-PUB-006 (5/12)



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

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

Name MEMIC Indemnity Company

Address 650 Elm Street Suite 401
Manchester NH 03101-2551

Phone 1-800-MEMIC WC

Employee Information

The Missouri Division of Workers' Compensation (DWC) administers programs for workers who have been injured on the job or exposed to an occupational disease arising out of and in the course of employment. The Division's Administrative Law Judges have the authority to approve settlements or issue awards after a hearing relating to an injured employee's entitlement to benefits.

Steps to Take When Injured on the Job

1. Notify your employer immediately (written notice must be provided within 30 days of the accident/or 30 days after the diagnosis of any occupational disease or repetitive trauma) by contacting

   ______________________________ , ____________________ .
   employer representative *phone number*

   ***Failure to do so may jeopardize your ability to receive benefits**

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

Benefits for Injured Employees

Medical Care:
The employer or insurer is required to provide medical treatment and care that is reasonably required to cure and relieve the effects of the injury. This includes all costs for authorized medical treatment, prescriptions, and medical devices. There is no deductible, and all costs are paid by the employer or its workers' compensation insurance company. If you receive a bill, **contact your employer or the insurance company immediately.** The employer/insurer has the right to choose the healthcare provider or treating physician. You may select a different healthcare provider or treating physician, but if you do so, it may be at your own expense.

Payment for Lost Wages:
- If a doctor says you are unable to work due to your injuries or recovery from a surgery, you may be entitled to **temporary total disability** (TTD) benefits. If a doctor says that you can perform light or modified duty work and your employer offers you such work, you may not be eligible for TTD benefits. TTD benefits should be continued until the doctor says you can return to work, or when your treatment is concluded because your condition has reached "maximum medical improvement," whichever occurs first.
- If you return to light or modified duty at less than full pay, you may be entitled to **temporary partial disability** benefits.

Permanent Disability Benefits:
If the injury or illness results in a permanent disability, you may be entitled to receive either permanent partial or permanent total disability benefits.

Survivor Benefits:
If a work-related injury causes an employee's death, the surviving dependents may receive weekly death benefits paid at 66 2/3% of the deceased employee's average weekly wage along with funeral expenses up to $5,000 from the employer/insurer. For additional information relating to survivor's benefits, including college scholarship opportunities for surviving children, please visit www.labor.mo.gov/DWC .

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

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

Workers' Compensation Law

Roles and Responsibilities for Employers and Employees

EMPLOYER INFORMATION

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

Steps to Take When an Injury Occurs

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

Workers' Safety

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

Fraud/Noncompliance

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

Employer Fraud – knowingly misrepresenting an employee's job classification or any other fact to obtain insurance at less than the proper rate is a class A misdemeanor. A subsequent violation is a class E felony. An employer who knowingly makes a false or fraudulent statement regarding an employee's entitlement to benefits to discourage the worker from making a legitimate claim or who knowingly makes a false or fraudulent material statement or material representation to deny benefits to a worker is guilty of a class A misdemeanor punishable by a fine of up to $10,000. A subsequent violation is a class D felony.

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

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

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

WC-106 (07-19) AI

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

Compañía de seguros, Administrador independiente, Compañía de servicios o Persona designada si tiene seguro propio

Nombre MEMIC Indemnity Company

Dirección 650 Elm Street Suite 401
Manchester NH 03101-2551

Teléfono 1-800-MEMIC WC

INFORMACIÓN DEL EMPLEADO

La División de Compensación a los Trabajadores de Missouri (DWC) administra programas para los trabajadores que se han lesionado en el trabajo o han estado expuestos a una enfermedad ocupacional que surge en el transcurso de su empleo. Los Jueces administrativos de la División tienen la autoridad para aprobar acuerdos o conceder indemnizaciones después de una audiencia relacionada con el derecho de un empleado lesionado a los beneficios.

Pasos a tomar si se lesiona en el trabajo

1. Notifique inmediatamente a su empleador (debe presentarse un aviso por escrito dentro de los 30 días de ocurrir una lesión o 30 días cuando se sabe de manera razonable de la relación de la enfermedad ocupacional con el trabajo) comunicándose con

   ______________________________ , ______________________ .
   representante del empleado *número de teléfono*

   ***No hacerlo puede poner en peligro la capacidad de recibir sus beneficios**
2. **Busque atención médica (su empleador/asegurador es responsable de proporcionarle el tratamiento médico y pagar los honorarios y gastos médicos, a menos que usted opte por visitar a otro médico, por su propia cuenta, sin la aprobación de su empleador/asegurador).**
3. Obtenga más información sobre los beneficios disponibles bajo el Programa de Compensación a los Trabajadores o sobre los pasos que debe seguir para obtener los beneficios que necesita.

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

Beneficios para los empleados lesionados

Cuidado médico:
El empleador o asegurador tiene que proporcionar tratamiento y cuidado médico para curar y aliviar los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. No hay deducibles y todos los costos los paga el empleador o su compañía de seguro de compensación a los trabajadores. Si usted recibe una factura, **comuníquese inmediatamente con su empleador o con la compañía de seguros.** El empleador o asegurador tiene derecho de escoger el proveedor de cuidado de salud o médico tratante. Usted puede seleccionar a otro proveedor de cuidado de salud o médico tratante, pero si lo hace, puede ser por su propia cuenta.

Pago por salarios perdidos:
- Si un médico dice que usted no puede trabajar debido a sus lesiones o a la recuperación de una cirugía, puede tener derecho a beneficios por **incapacidad total temporal** (TTD). Si un médico dice que usted puede realizar labores livianas o modificadas de trabajo y su empleador le ofrece dicho trabajo, puede que no sea elegible para beneficios de TTD. Los beneficios de TTD deben continuar hasta que el médico diga que usted puede volver a trabajar o cuando su tratamiento haya terminado porque su condición ha alcanzado la "máxima mejoría médica", lo que ocurra primero.
- Si usted regresa a trabajar en labores ligeras o modificadas por menos del salario completo, puede que tenga derecho a recibir beneficios por **incapacidad parcial temporal.**

Beneficios por incapacidad permanente:
Si la lesión o enfermedad da lugar a una incapacidad permanente, usted puede tener derecho a recibir beneficios ya sea por incapacidad parcial permanente o por incapacidad total permanente.

Beneficios de sobreviviente:
Si un empleado muere en el trabajo, los dependientes que le sobrevivan pueden recibir beneficios por muerte semanales pagados al 66 2/3% del salario promedio semanal del empleado fallecido, junto con gastos funerarios de hasta $5,000 por parte del empleador/asegurador. Para información adicional relacionada con los beneficios de sobreviviente, incluyendo oportunidades de becas universitarias para hijos sobrevivientes, visite www.labor.mo.gov/DWC.

La División de Compensación a los Trabajadores de Missouri es un empleador/programa con igualdad de oportunidades. Hay recursos y servicios disponibles para personas discapacitadas si se solicitan.

Ley de Compensación a los Trabajadores

Papel a desempeñar y responsabilidades de empleadores y empleados

INFORMACIÓN DEL EMPLEADOR

Salvo algunas excepciones, todos los empleadores que tengan cinco o más empleados y los empleadores de la industria de la construcción que tengan uno o más empleados tienen que garantizar la obligación legal de la compensación a sus trabajadores, ya sea comprando una póliza u obteniendo la autoridad de tener seguro propio. El seguro de compensación a los trabajadores proporciona beneficios a los trabajadores que se lesionan en el trabajo. Los empleadores también tienen que exhibir este aviso en el lugar de trabajo de manera que los empleados lo vean. Este póster es obligatorio conforme a la sección 287.127, Estatutos Revisados de Missouri, y está disponible para empleadores y aseguradores sin costo alguno a través de la División llamando al 800-775-Comp.

Pasos a tomar si ocurre una lesión

1. Asegúrese de que se le den los primeros auxilios y lleven al empleado al médico o al hospital para recibir atención médica adicional, si es necesario.
2. Informe sobre la lesión a la compañía de seguros o Administrador externo (TPA) dentro de un plazo de cinco días a partir de la fecha de la lesión o de la fecha en que el empleado informó al empleador sobre la lesión, lo que ocurra más tarde. El asegurador, TPA o el asegurador por cuenta propia reconocido es responsable de presentar un Primer Informe de Lesión ante la División de Compensación a los Trabajadores **dentro de los 30 días** de haber tenido conocimiento de la lesión.
3. Pague las facturas médicas relacionadas con la lesión en el trabajo para curar y aliviar al empleado de los efectos de la lesión. Esto incluye todos los costos del tratamiento médico autorizado, medicamentos recetados y aparatos médicos. El empleador tiene derecho de escoger el proveedor de cuidado de la salud o médico trat ante. (El empleado puede seleccionar a otro proveedor de cuidado de la salud o médico tratante, pero si lo hace, puede ser por su propia cuenta) .
4. Para más información de seguro y responsabilidad relacionados con el Programa de Compensación a los Trabajadores, visite www.labor.mo.gov/DWC o llame al 800-775-COMP.

Seguridad de los trabajadores

Desarrollar e implementar un programa completo de salud y seguridad puede reducir las lesiones ocupacionales y ayudar a reducir los gastos de compensación a los trabajadores. Las compañías aseguradoras en el estado de Missouri tienen que proporcionar asistencia en seguridad cuando un empleador asegurado la solicita. El Departamento del Trabajo de Missouri evalúa estos servicios y brinda ayuda adicional a través de su Programa de Seguridad de los Trabajadores de Missouri.
Visite www.labor.mo.gov/MWSP o llame al 573-751-4231 para obtener más información sobre estos programas o un registro de consultores independientes que están certificados en el estado de Missouri para proporcionar asistencia en seguridad.

Fraude/Falta de cumplimiento

Fraude del empleado - presentar a sabiendas una reclamación de beneficios por compensación a los trabajadores a los cuales el empleado sabe que no tiene derecho o presentar a sabiendas múltiples reclamaciones por el mismo incidente con intención de defraudar es un delito grave de clase D, que se castiga con una multa de $10,000 o del doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

Fraude del empleador - alterar a sabiendas la clasificación de empleo de un empleado con el objetivo de obtener seguro a una tarifa menor de la que corresponde es un delito menor de clase A. Una infracción posterior es un delito grave de clase D. Un empleador que hace una declaración falsa o fraudulenta a sabiendas relacionada con el derecho de un empleado a recibir beneficios con el objetivo de disuadir al trabajador de presentar una reclamación legítima, o que hace una declaración o descripción fundamental falsa o fraudulenta a sabiendas para negar beneficios a un trabajador es culpable de un delito menor de clase A que se castiga con una multa de hasta $10,000. Una infracción subsiguiente es un delito grave de clase C.

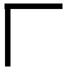
Fraude del asegurador - negarse, a sabiendas y deliberadamente, a cumplir con las obligaciones de la compensación a los trabajadores a la cual la compañía de seguros o asegurador por cuenta propia sabe que un empleado tiene derecho es un delito grave de clase D que se castiga con una multa de hasta $10,000 o el doble del valor del fraude, lo que sea mayor. Una infracción posterior es un delito grave de clase C.

Falta de cumplimiento del empleador - no garantizar, a sabiendas, la obligación de la compensación a los Trabajadores es un delito menor de clase A que 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 infracción posterior es un delito grave de clase D. Un empleador que intencionalmente no coloca el anuncio de la compensación a los trabajadores en el lugar de trabajo es culpable de un delito menor de clase A que se castiga con una multa de $50 a $1,000, o prisión o ambas.

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE



UNIVERSITY OF MAINE SYSTEM
3845 VINAL LAKE ROAD
TROY MT 59935-0000

Date: 10/01/2020

Policy Number: 310 2805098

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of **10/01/2020 to 10/01/2021**, provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

1-800-636-4292

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50 FINE AGAINST THE EMPLOYER!

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

Compensación de Trabajadores

Cobertura De Seguro

AVISO DEL EMPLEADO

UNIVERSITY OF MAINE SYSTEM
3845 VINAL LAKE ROAD
TROY MT 59935-0000

Fecha: 10/01/2020

Número de la Políza:
310 2805098

La cobertura de compensación para trabajadores de la antedicha compañia esta vigente por el periodo de **10/01/2020** al **10/01/2021** , mientras tanto que la compañía halla reunido todos los requisitos de reportes y la prima.

SI USTED ES HERIDO

Usted debe informar cualquiera lesion que ocurre en el trabajo a su supervisor, el empleador o el asegurador tan pronto posible. Usted tiene que reportar el accidente dentro de 30 días. Un propietario único, el socio, el director de una compañía manejado por el director de obligación limitada, el miembro de una compañía miembro-manejado por obligación limitada, oficial corporativo cubierta bajo el Acto de Compensación de Trabajadores de Montana debe informar un accidente al asegurador dentro de 30 días.

Informe las lesiones secundarias a su empleador aunque usted no reciba tratamiento médico. Después que usted informa la lesión, su empleador tiene 6 días para notificar a su asegurador. Usted tiene que entregar un escrito "Primer Informe de la Lesion" dentro de 12 meses de la fecha del accidente o dentro de un (1) año del conocimiento de una enfermedad profesional. Usted le puede entregar esta forma a su empleador, al asegurador, o al Departamento de Labor y de Industria.

Todos los empleados que sostienen una lesion compensable relacionada al trabajo o la enfermedad profesional, con excepción de las que sean eximidas por el estatuto (la Sección 39-71-401, MCA), son cubierta por médico y por los beneficios de perdida de salario.

Antes de la designación de la Aseguradora o aprobación de un médico tratante puede elegir su proveedor de atención médica inicial.

Usted puede continuar recibiendo tratamiento de su proveedor de atención médica inicial a menos que el asegurador designa un médico tratante que no sea su proveedor de atención médica inicial. Después de proporcionarle con un aviso de un designado o aprobado médico tratante, el asegurador es no más obligado para el tratamiento proporcionado por otros proveedores de asistencia médica a menos que autorización sea obtenida para continuar el tratamiento.

Para información específica sobre esta políza, llame o escriba al portador del seguro de su empleador:

MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

1-800-636-4292

Para información general acerca la compensación de los trabajadores, llame o escriba:

¡EL FRACASO DE ANUNCIAR ESTE LETRERO O ANUNCIAR UN LETRERO MODIFICADO EN EL LUGAR DE TRABAJO RESULTA EN UNA MULTA DE $50 CONTRA EL EMPLEADOR!

Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Teléfono (406) 444-6532.

ERD (Rev 1/1/19)

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer … shall provide and secure compensation … for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer …. if: (a)The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "… every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "… any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

PART 1 OF 2 – TAPE BOTTOM OF POSTER HERE

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or

2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1- 888-333-1597, Web site: http://dhhs.nv.gov/Programs/CHA , E-mail cha@govcha.nv.gov

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: MEMIC Indemnity Company   Contact Person: Executive Underwriter

Address: Manchester NH 03101-2551   Telephone Number: 1-800-636-4292
City State Zip

MCO/Health Care Provider: ____________   Contact Person: ____________

Address: ____________   Telephone Number: ____________
City State Zip

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

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NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer as Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:

   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;

   (b) Submit the copy of its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and

   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. § 6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

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: MEMIC Indemnity Company

Phone #: 1-800-636-4292

Address: 650 Elm Street Suite 401

Manchester NH 03101-2551

Note: Employer must fill in this insurer / claims representative information.

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PART 1 OF 2
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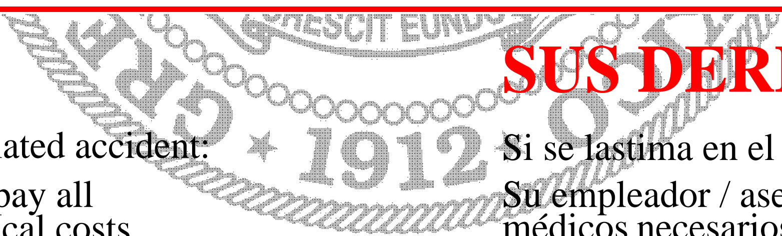
YOUR RIGHTS



If you are injured in a work-related accident:

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

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WCA POSTER (BOTTOM)
PART 2 OF 2

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

1-866-WORKOMP (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.

11/18

O
POST FORMS HERE

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
PO Box 27198, Albuquerque, New Mexico 87125-7198

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

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

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

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

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

What happened?____
¿Qué ocurrió?

To be completed by Employer:
Completado por el empleador:

Worker will choose health care provider. Yes ___ No ___
Trabajador elegirá proveedor de atención médica.

If Yes, Employer has right to change health care provider after 60 days. If No, Worker has the right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 dias. *En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*

WORKER'S INITIALS ______ *INICIALES DEL TRABAJADOR*

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

Date/Fecha:________________ Date/*Fecha*: ________________

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

Form NOA-1 **Employer/employee: Each keep one copy.** **Empleador/empleado: Retener una copia.**

----SEE BACK OF THIS FORM----
----VER AL REVERSO DE ESTA FORMA--

Worker --

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

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

Trabajador

Para emergencias médicas vaya a cualquier clinica / hospital.

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

Statewide Helpline -- ***Linea de Asistencia***

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

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

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

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Hobbs: (575) 397-3425 - 1 (800) 934-2450
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381

FORM 17 Revised 10/2017

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

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

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

The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.
- Your employer's compensation insurance carrier is MEMIC Indemnity Company.
- The insurance policy number is 310 2805098.
- Your employer's workers' compensation insurance policy is valid from 10/01/2020 until 10/01/2021.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

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

FORMA 17 Revisada 11/2017

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

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

El Empleado deberá:

- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional.**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia.**
- **Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es** MEMIC Indemnity Company .
- **El número de la póliza de seguro es** 310 2805098 .
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde** 10/01/2020 hasta 10/01/2021 .

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

El Empleador deberá:

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

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

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

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

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

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, 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

MEMIC Indemnity Company
650 Elm Street Suite 401, Manchester, NH, 03101-2551.

Insurer Name and Address

10/01/2021

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 85A for the injury, six (6) months from the date of the last issuance of such benefits; a death claim must be filed within two (2) years of the date of death; a claim for compensation for occupational disease or illness must be filed within two (2) years of the last injurious exposure; and a claim for compensation for cumulative trauma must be filed 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 filing 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, 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. 11-21-19

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 y enfermería, medicina, muletas y otros aparatos que sean razonablemente necesarios en relación con 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

MEMIC Indemnity Company
650 Elm Street Suite 401, Manchester, NH, 03101-2551.

Nombre y Dirección del Asegurador

10/01/2021

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, 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 compensación 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 11-21-19

Este aviso debe ser publicado y mantenido por el empleador en uno o más lugares visibles en el lugar de trabajo.

SAFETY

AVOID THE WORST

BE PART OF THE
SAFETY TEAM

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-EZE-OIEC (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 a workers' compensation adjuster's license and 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.

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28 TAC §276.5. Employer Notification of Ombudsman Program to Employees (Effective 9/1/13)
(a) All employers participating in the workers' compensation system shall post notice of the Office of Injured Employee Counsel's (OIEC) Ombudsman Program. This notice shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis.
(b) This notice of the Ombudsman Program shall be publicly posted in English, Spanish, and any other language that is common to the employer's employees.
(c) This notice shall be the text provided by OIEC without any additional words or changes and may be obtained by:
 (1) Downloading the form on OIEC's website at: www.oiec.texas.gov; or
 (2) Requesting the notice by calling OIEC's toll-free telephone number at: 1-866-EZE-OIEC (1-866-393-6432).

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que ayuda a los empleados que no cuentan con representación legal con sus reclamaciones en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-EZE-OIEC (1-866-393-6432). Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio Web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que puede asistirle si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte de un Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation). Una vez que el procedimiento haya sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

Código Administrativo de Texas No. 28 (28 Texas Administrative Code –TAC, por su nombre y siglas en inglés) §276.5. Aviso del Empleador sobre el Programa de Ombudsman para los Empleados (A partir de 9/1/13)

(a) Todos los empleadores que participan en el sistema de compensación para trabajadores deberán mostrar el aviso sobre el Programa de Ombudsman de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC). Este aviso deberá ser mostrado en la oficina de personal, si es que el empleador cuenta con una oficina de personal, y en el área de trabajo donde cada empleado probablemente podrá ver el aviso de manera regular.

(b) Este aviso del Programa de Ombudsman deberá ser públicamente mostrado en inglés, español, y cualquier otro idioma que sea común para la población de los trabajadores del empleador.

(c) Este aviso deberá contener el texto que es proporcionado por OIEC sin ninguna palabra adicional o cambios y se puede obtener:

(1) Descargando el formulario del sitio Web de OIEC en: www.oiec.texas.gov; o

(2) Solicitando el aviso llamando al número de teléfono gratuito de OIEC al: 1-866-EZE-OIEC (1-866-393-6432).

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] UNIVERSITY OF MAINE SYSTEM has workers' compensation insurance coverage from [name of commercial insurance company] MEMIC Indemnity Company . In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] 10/01/2020 . Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] MEMIC Indemnity Company . 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: [Name of the employer] UNIVERSITY OF MAINE SYSTEM tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] MEMIC Indemnity Company para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] 10/01/2020 . Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance policy] MEMIC Indemnity Company . Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta(30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

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

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

EMPLEADOR CON COBERTURA

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

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

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

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

NO MOSTRAR ESTE LADO

REQUIRED WORKERS' COMPENSATION COVERAGE

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

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

TO THE EMPLOYER/CONTRACTOR:

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

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

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

COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

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

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

AL EMPLEADOR/CONTRATISTA:

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

(1) ser puesto a la vista en inglés, español y cualquier otro idioma común para la población de los empleados del empleador
(2) ser mostrado en cada sitio del proyecto
(3) indicar cómo una persona puede verificar la cobertura actual y cómo se puede reportar en caso de que no se proporcione una cobertura
(4) ser impreso con un título en letras de por lo menos un tamaño de 30 puntos en letra negrita, y el texto en por lo menos un tamaño de 19 puntos tipo normal; y
(5) contener las palabras exactas tal como se ha señalado en el Reglamento 110.110 (d)(7).

El aviso que se muestra al reverso de esta página cumple con los requisitos señalados en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido por este reglamento es una violación a la Ley de Compensación para Trabajadores de Texas y a los Reglamentos. El infractor puede estar sujeto a recibir multas administrativas.

WORKERS' COMPENSATION NOTICE

Employer: UNIVERSITY OF MAINE SYSTEM

has complied with the provisions of the Workers' Compensation Act (§34A-2-101, Utah Code Annotated), the Utah Occupational Disease Act (§34A-3-101, Utah Code Annotated), and the rules of the Labor Commission by insuring the liability to pay the compensation and other benefits provided by said Acts through:

Insurance Company: MEMIC Indemnity Company

Policy Number: 310 2805098 04

Address for the above insurance company: 650 Elm Street Suite 401, Manchester NH 03101-2551

Telephone number: 1-800-MEMIC WC

☐ Check here if the employer has been authorized by the Division of Industrial Accidents to self-insure and directly pay workers' compensation benefits.

WORKERS' COMPENSATION

Workers' Compensation is insurance which pays medical expenses and helps offset lost wages for employees with work-related injuries or illnesses. If you have an on-the-job injury or occupational disease, it may pay for: hospital and medical bills, time lost from work, permanent loss of body function, prosthetic devices, and burial and dependent benefits in case of death.

HOW TO REPORT AN ACCIDENT

1. Report the injury, no matter how slight, immediately to your supervisor. You may lose your rights if your injury is not reported within 180 days of the injury or work-related illness.
2. Ask your employer where you should go for treatment. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.
3. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a physician's initial report form. A copy of the report is given to you and copies of the report are sent to the insurance company and the Labor Commission within seven (7) days of your doctor visit.
4. Your employer shall fill out the employer's first report of injury form. A copy of this report is sent to the insurance company within seven (7) days of the accident. The insurance company will report the injury to the Labor Commission.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation benefits for the company.
2. Ask your employer to report the accident to the insurance company and give you the claim number.
3. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the employer's report, the physician's report, and may ask you to fill out a request for compensation. Cooperate with the adjuster's investigation of the injury.
4. Ask your doctor to send medical reports to the insurance company, including the work status statement.

REHABILITATION

If you cannot return to work, you may be eligible for a rehabilitation program. Contact the insurance company listed above or the Utah State Office of Rehabilitation.

FRAUD STATEMENT: "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Office: (801)-530-6800 Fax: (801)-530-6804 Toll Free: (800)-530-5090 www.laborcommission.utah.gov

If you want copy of an *Employee's Guide to Workers' Compensation* booklet or have questions, contact the Labor Commission or go to the webpage at www.laborcommission.utah.gov

Note: This notice must be posted and kept continuously in public and conspicuous places in the office, shop or place of business of the employer as per §34A-2-204 and §34A-2-104.5, Utah Code Annotated.

Rev 10/2019

AVISO DE COMPENSACIÓN PARA LOS TRABAJADORES

La Empresa: UNIVERSITY OF MAINE SYSTEM

Ha cumplido con las disposiciones de la Ley de Compensación para los Trabajadores (§34A-2-101, Código de Utah Anatado), la Ley de Enfermedades Ocupacionales de Utah (§34A-3-101, Código de Utah Anatado), y las reglas de la Comisión Laboral por asegurando la obligación de pagar compensactión y otros beneficios preveidos por las Leyes y teniendo coberturacon:

Compañía de Seguros: MEMIC Indemnity Company

Numero de Póliza: 310 2805098 04

Dirección de la compañía de seguros: 650 Elm Street Suite 401, Manchester NH 03101-2551

Numero de teléfono: 1-800-MEMIC WC

☐ Marque aquí si la División de Accidentes Industriales ha autorizado el empleador a tener el auto-seguro y pagar los beneficios de compensación directamente al trabajador.

COMPENSACIÓN PARA LOS TRABAJADORES

Compensación para los trabajadores es un seguro que paga los gastos médicos y ayuda a compensar los salarios perdidos de los empleados con lesiones o enfermedades relacionadas con el trabajo. Si usted tiene una lesión en el trabajo o una enfermedad occupasional, puede pagar: facturas hospitalarias y médicas, pérdida de tiempo del trabajo, pérdida permanente de la función corporal, dispositivos protésicos y servicios funerarios y beneficios para dependientes en caso de muerte.

COMO REPORTAR UN ACCIDENTE

1. Informe inmediatamente a su supervisor de la lesión. Usted puede perder sus derechos si no reporte su lesión o enfermedad relacionada con el trabajo dentro de 180 días.
2. Pregunte a su empleador dónde debe ir para recibir tratamiento. Si su empleador tiene un clínico designado, vaya allí de inmediato para recibir tratamiento. Si no tiene un clínico designado, vaya a un médico de su elección.
3. Informe al doctor CÓMO, CUÁNDO y DÓNDE ocurrió el accidente. El médico llenará el formulario de informe inicial del médico. Usted debe recibir una copia del informe y copias se envían a la compañía de seguros y a la Comisión Laboral dentro de siete (7) días de su visita al médico.
4. Su empleador llenará el formulario de informe inicial del empleador. Usted debe recibir una copia del informe y una copia se envía a la compañía de seguros dentro de siete (7) días. La compañía de seguros es responsable a reportar a la Comisión Laboral.

COMO EMPEZAR COMPENSACIÓN

1. Pregunte a su empleador qué compañía de seguros pagará los beneficios de compensación para los trabajadores.
2. Pídale a su empleador que reporte el accidente a la compañía de seguros y que le dé el número de reclamo.
3. Llame a la compañía de seguros y pídales que inicien sus beneficios de compensación para trabajadores. La compañía de seguros requerirá el informe del empleador, el informe del médico, y puede pedirle a usted que llene una solicitud de compensación. Cooperar con la investigación del ajustador sobre la lesión.
4. Pídale a su médico que envíe informes médicos a la compañía de seguros, incluyendo la declaración de estado de trabajo.

REHABILITACIÓN

Si no puede regresar al trabajo, puede ser elegible para un programa de rehabilitación. Póngase en contacto con la compañía de seguros mencionada anteriormente o con la Oficina de Rehabilitación del Estado de Utah.

DECLARACIÓN DE FRAUDE: “Cualquier persona que a sabiendas presente información falsa o fraudulenta de suscripción de seguros, archivos o causas para presentar una reclamo falso o fraudulento por compensación de incapacidad o beneficios médicos, o presente un informe o facturación falsa o fraudulenta por gastos médicos u otros servicios profesionales es culpable de un crimen y pueden ser sujetos a multas y confinamiento en una prisión estatal.”

160 East 300 South 3rd Floor P.O. Box 146610 Salt Lake City, Utah 84114-6610
Teléfono: (801)-530-6800 Fax: (801)-530-6804 Línea gratuita: (800)-530-5090 www.laborcommission.utah.gov

Si desea una copia del folleto de *la Guía Sobre el Seguro de Compensación Para los Trabajadores* o tiene preguntas, comuníquese con la Comisión Laboral o visite la página web en www.laborcommission.utah.gov.

Nota: Este aviso debe ser publicado y mantenido continuamente en lugares públicos y visibles en la oficina, tienda o lugar de negocios del empleador según §34A-2-204 y §34A-2-104.5, Código de Utah Anatado.

Rev 10/2019

Insurance Privacy Notice

Last Updated: January 1, 2020

This Privacy Notice assists our policyholders, their injured workers and independent insurance agents to understand how The MEMIC Group (comprised of Maine Employers' Mutual Insurance Company, MEMIC Casualty Company, and MEMIC Indemnity Company), hereinafter referred to as "**we**," "**us**," "**our**" or "**MEMIC**," collects, uses, shares and safeguards Personal Information. For purposes of this Privacy Notice, "**Personal Information**" means information that identifies, relates to, describes, is reasonably capable of being associated with, or could reasonably be linked, directly or indirectly, with a particular person in connection with our insurance policies or insurance-related offerings.

For details about the information we may collect from website visitors and links to other specific privacy notices, please review MEMIC's Website Privacy Notice (available at https://www.memic.com/privacy-policy).

Insurance Information

In order to evaluate, underwrite and administer the insurance policies and insurance-related products for our policyholders, we collect Personal Information about our policyholders' injured workers and other employees, as well as information about other persons involved in or witnessing potential claims ("**Insurance Information**"). We collect and process Insurance Information on behalf of our policyholders for business purposes, and we retain, use and disclose Insurance Information only as necessary to provide the insurance-related services we have agreed to provide our policyholders.

For purposes of the California Consumer Privacy Act of 2018 ("**CCPA**"), this means we are acting as a "Service Provider" on behalf of our policyholders and do not have any direct obligations as a "Business" under the CCPA in relation to Insurance Information. As a result, injured workers and other policy holder employees wishing to exercise any rights under the CCPA in relation to Insurance Information should direct requests to their employer who holds a policy with us. Although the rights of injured workers and other employees may be limited under the CCPA due to an exception applicable to personnel, the relevant policy holder will determine the extent to which the CCPA and its associated consumer rights may apply to Insurance Information. We recommend that all policyholders discuss their legal obligations under the CCPA with counsel to determine their responsibilities in relation to Insurance Information.

Personal Information We Collect

The types of Personal Information we collect depends on the products and services requested and may include the following:

- Information we receive from policyholders, agents, injured workers and other persons involved in or witnessing potential claims through applications and other forms, phone interviews and other correspondence, including name, physical address, social security number, date of birth, email address, phone number, type of injury, health information, financial information (including financial account information), family information, occupation, wages, and employment history;
- Information about policyholders' and independent agents' transactions with us, our subsidiaries and others, including products and services requested from us, as well as payments and claims history;
- Information from third parties such as consumer reporting agencies, medical providers and third parties using investigative techniques permitted by law, including database searches, surveillance, and interviews; and
- Information about injured workers' transactions and claims in relation to the policy under which they may be covered.

How We Use Personal Information We Collect

We use Personal Information to fulfill requests for insurance and insurance-related services, including to help us identify a particular person as a policy holder, as an injured worker or as an independent agent; to process requests and transactions; to offer insurance and insurance-related services; to pay claims to eligible persons; to analyze and enhance our products and services, as permitted by law; to tell policyholders and independent agents about our products or services we believe they may want and use; and as otherwise permitted by law.

If you request something from us, such as information or a service related to insurance or benefits, we use the Personal Information you provide to verify your identity and fulfill your request. We also use Personal Information to conduct our business, such as by administering claims, conducting audits and servicing insurance policies.

How We Share Personal Information We Collect

In the course of our business practices we may disclose Personal Information that we collect to our subsidiaries and the following types of persons and/or entities:

- Policyholders and injured workers to provide information relevant to their policies or claims;
- Third parties performing business, professional, or insurance functions for us, such as legal services providers, fraud investigation providers, external auditors, in-person and remote medical services providers, travel providers, and billing and payment processors;
- Insurance support organizations performing functions in connection with an insurance transaction, such as third-party administrators;
- Insurance regulatory authorities, law enforcement, or other governmental entities to prevent or prosecute fraud and to comply with legal obligations; and
- Third parties at an individual's request or when the individual gives us permission to do so, such as medical providers, pharmacies, third-party insurance providers and financial institutions.

We endeavor to prohibit third parties accessing your Personal Information on our behalf from retaining, using or disclosing Personal Information for any purpose other than for the specific purpose of performing the services specified in a contract with us.

Where permitted or required by law, we may also disclose Personal Information to third parties to comply with court orders, subpoenas, or other legal or regulatory requirements or requests, or to exercise our legal rights to defend against legal claims.

In addition, Personal Information collected may be transferred to or assigned to another entity, in connection with a potential or actual merger, acquisition, reorganization, bankruptcy or similar event, if permitted by and done in accordance with applicable law.

How We Safeguard Personal Information

We use a variety of physical, technical and administrative safeguards designed to protect Personal Information from unauthorized access, use and disclosure. We also protect Personal Information by taking steps designed to only allow access to such information by employees and authorized parties who have a legitimate and verified need to access the information in order to service your requests and administer policies and claims.

Review and Correction of Personal Information

When directed by a policy holder, we endeavor to provide individuals access to the Personal Information we have collected about them, except for Personal Information contained in certain documents related to claims and/or legal proceedings. If an individual believes their Personal Information is incomplete or inaccurate, the relevant policy holder should contact us and we will investigate whether any correction of Personal Information may be necessary.

Contact Us

You may contact us via email at privacy@memic.com or write to:

The MEMIC Group
Director of Risk Management
261 Commercial Street
P.O. Box 11409
Portland, ME 04104

Updates to Privacy Notice

Last Updated: January 1, 2020

IMPNOTICE26D

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us – MEMIC Indemnity Company

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

MEMIC Indemnity Company
650 Elm St. Suite 401
Manchester, NH 03101
Telephone: 800-660-1306
Fax: 207-791-3336
www.memic.com

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

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

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

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

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

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

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

II. Dispute Process

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

A. Our Dispute Resolution Process.

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:
MEMIC Indemnity Company. PO Box 11409, Portland, ME 04104. Telephone: 800-660-1306. Fax: 207-791-3336.

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

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

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

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

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

Administrative Hearing Bureau
California Department of Insurance
1901 Harrison Street, 3rd Floor
Oakland, CA 94612
415.538.4243

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

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

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159 (phone), 415.371.5288 (fax) and ombudsman@wcirb.com (email).

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

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

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

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

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

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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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 estab- lished 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.

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NOTICE REQUIRED BY LAW – CALIFORNIA

Since our offer to renew your coverage reflects a premium rate increase of 25 percent or more in your governing classification, California law (Insurance Code section 11664) requires us to send you a "notice of nonrenewal", even though we do intend to renew your policy. This constitutes the required notice. For purposes of this Notice, premium rate means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

Insured UNIVERSITY OF MAINE SYSTEM

Date of Notice 10/01/2020

Policy No. 310 2805098 04

Policy Period 10/01/2020 - 10/01/2021

POLICY HOLDER NOTICE

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent, the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" or "CA Surcharge (CIGA Surcharge)" with an amount will be displayed on your premium notice.

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

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POLICYHOLDER NOTICE

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

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

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

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

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

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

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

Audit Requirements
If your policy has an effective date on or after January 1, 2020 and produces a final premium of $10,500 or more, a physical audit is required at least once a year; if it produces a final premium of less than $10,500 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

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

POLICYHOLDER NOTICE

CALIFORNIA ASSEMBLY BILL NO. 5, INDEPENDENT CONTRACTORS

Summary of Assembly Bill No. 5 (AB 5)
For the purposes of wages, workers' compensation and other benefits, AB 5 creates a presumption that an entity's workers are employees unless the hiring entity can show that the worker meets three conditions, known as the "ABC Test". With respect to workers' compensation, AB 5 goes into effect on **July 1, 2020** and applies to policies issued on or after **July 1, 2020,** as well as policies in force as of **July 1, 2020.**

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

2750.3.
(a)(1) For purposes of the provisions of this code and the Unemployment Insurance Code, and for the wage orders of the Industrial Welfare Commission, a person providing labor or services for remuneration shall be considered an employee rather than an independent contractor unless the hiring entity demonstrates that all of the following conditions are satisfied:

(A) The person is free from the control and direction of the hiring entity in connection with the performance of the work, both under the contract for the performance of the work and in fact.

(B) The person performs work that is outside the usual course of the hiring entity's business.

(C) The person is customarily engaged in an independently established trade, occupation, or business of the same nature as that involved in the work performed.

(2) Notwithstanding paragraph (1), any exceptions to the terms "employee," "employer," "employ," or "independent contractor," and any extensions of employer status or liability, that are expressly made by a provision of this code, the Unemployment Insurance Code, or in an applicable order of the Industrial Welfare Commission, including, but not limited to, the definition of "employee" in subdivision 2(E) of Wage Order No. 2, shall remain in effect for the purposes set forth therein.

(3) If a court of law rules that the three-part test in paragraph (1) cannot be applied to a particular context based on grounds other than an express exception to employment status as provided under paragraph (2), then the determination of employee or independent contractor status in that context shall instead be governed by the California Supreme Court's decision in *S.G. Borello & Sons, Inc. v. Department of Industrial Relations* (1989) 48 Cal.3d 341.

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

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

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

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

The Terrorism Risk Insurance Act of 2002 (TRIA), as previously amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015 (TRIPRA 2015), provides for a program under which the federal government will share in the payment of insured losses caused by certain acts of terrorism. In the absence of affirmative US Congressional action to extend, update, or otherwise reauthorize TRIPRA 2015, in whole or in part, TRIPRA 2015 is scheduled to expire on December 31, 2020.

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

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

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

You need not do anything further at this time.

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: ______________________________

Date Program Implemented: ______________________________

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: ______________________________

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

B. Phone No.: (   ) ______________________________

C. Address: ______________________________

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

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

______________________	____________	______________________
Employer Name	Date	Officer/Owner Signature*
		______________________
		Title

*Application must be signed by an officer or owner.

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CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: ____

Name of Contact Person: ______________________________ Telephone #: ____________________

Policy #: ____ Effective Date of Policy: ____________

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.

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Wolters Kluwer Financial Services, Inc. | Uniform Forms

(Ed. 05-14)

IMPORTANT POLICYHOLDER NOTICE

DIRECT PAYMENT OF WORKERS' COMPENSATION CLAIMS PROHIBITED - ARKANSAS

Please be advised that directly paying medical bills for injured workers may be considered a violation of Arkansas Code Ann. 11-9-106(a), which deals with making materially false representations for the purpose of avoiding payment of the proper insurance premium.

Although Arkansas Code Ann. 11-9-813 authorizes us to offer you deductibles, you are not authorized to make direct payments on claims under the deductible amount. The law does not allow for such direct payments, WITH OR WITHOUT A VALID DEDUCTIBLE PROGRAM.

Even with an authorized deductible program, all claims must be submitted to us for “first dollar” payment by us. You are then obligated to reimburse us for any deductible amounts we have paid.

(Ed. 05-14)

IMPORTANT POLICYHOLDER NOTICE

ACCIDENT PREVENTION SERVICES - ARKANSAS

We are required to provide policyholders with certain accident prevention services at no additional cost as required by Ark. Code Ann. 11-9-409(d) and AWCC Rule 32. If you would like more information, call our Loss Control Department at 1-800-660-1306. If you have any questions about this requirement, call the Health & Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

IMPORTANT POLICY HOLDER NOTICE

LOSS CONTROL CONSULTATION SERVICES

In accordance with California Labor Codes 6354.5, we shall provide occupational safety and health loss control consultation services to you at no additional cost.

These services shall be adequate to identify the hazards exposing you to, or causing you, significant workers' compensation losses, and to advise you of steps needed to mitigate the identified workers' compensation losses or exposures. Our loss control consultation services shall provide all of the following:

(1) A workplace survey, including discussions with management and, where appropriate, non-management personnel with your permission.

(2) A review of injury records with appropriate personnel.

(3) The development of a plan to improve your health and safety loss control experience, which shall include, where appropriate, modifications to your injury and illness prevention program established pursuant to Section 6401.7.

Workers' Compensation insurance policyholders may register comments about the insurer's loss control consultation services by writing to: State of California, Department of Industrial Relations, Division of Occupational Safety and Health, P.O. Box 420603, San Francisco, CA 94142.

COLORADO COST CONTAINMENT AND SELECTION OF DESIGNATED MEDICAL PROVIDER DISCLOSURE

Cost Containment Certification

You may be entitled to a possible premium dividend if your Risk Management Program is certified by the Colorado Cost Containment Board.

If you are experience or schedule rated, you have implemented a certified Workers' Compensation risk management program and your loss experience has improved since your last Workers' Compensation renewal date, you may receive a 5% premium dividend. The premium dividend will be in addition to the maximum schedule rating deviation of 25%. The schedule rating and cost containment discounts will be applied multiplicatively. Therefore, the maximum schedule rating credit (0.75) multiplied by the cost containment certification premium dividend (0.95) cannot exceed 28.75%.

If you do not qualify for experience and/or schedule rating and you have implemented a certified workers' compensation risk management program, then the following premium dividend must be allowed:

- 10% If you have been loss free for at least the last year immediately preceding the effective date of the premium dividend.
- 8% If you have had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium dividend.
- 6% If you have had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium dividend.
- 4% If you have had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium dividend.
- 2% If you have had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium dividend.
- 0% If you have had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium dividend

The application of the premium dividend up to 10% shall be dependent on available loss statistics on the initial and the renewal date of premium dividends. However, if loss statistics are not available at the initial or renewal date of the premium dividend, such loss statistics shall be applied on the subsequent renewal date. If you change insurers, the replaced insurer must furnish such loss statistics to you prior to the effective date of the new policy.

Designated Medical Provider

You may also be entitled to a premium differential of 2.5% if you select a designated medical provider. If you are eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation. If you allow the premium differential in the schedule rating you must report the premium differential separately to the rating/advisory organization to capture this information.

If you are not eligible for experience or schedule rating, the 2.5% credit shall be applied, in addition to the premium dividend applicable. The combined premium dividend and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%.

In order to be eligible for a premium dividend, your policy file must contain a completed copy of this form.
Complete and return to:

MEMIC
P.O. Box 11409
Portland, Maine 04104

Signature of Insured Representative	Printed Name & Title	Date

Named Insured	Policy Number	Policy Effective Date

IMPORTANT POLICYHOLDER NOTICE

COLORADO NOTICE OF DEDUCTIBLE

In accordance with Colorado Revised Statute, 8-44-111, we are notifying you that a $10,000 per claim deductible is available upon request. If you decide to select the $10,000 deductible, claims will be paid by us and you will be liable for reimbursement up to the deductible limit.

Please contact your agent if you are interested in having this deductible applied to your policy.

IMPORTANT POLICYHOLDER NOTICE

NOTICE OF FLORIDA DEDUCTIBLE PROGRAM

In accordance with Florida Title XXXI § 440.20, we are notifying you that a state-authorized deductible plan is available. Under this plan, you may pay, for each injury for which an employee files a claim under this chapter as a deductible, up to the first $2,500 of the total amount payable under compensable claims related to such injury. You must not be reimbursed for any amount paid under this provision. Any amounts you pay under this provision may not apply in any way to your experience rating.

There is no premium credit associated with this deductible option.

Please contact your agent if you are interested in having this deductible applied to your policy.

IMPORTANT POLICYHOLDER NOTICE

CONTACT INFORMATION

In accordance with Florida Statute 627.4131, we are required to provide you with our telephone number. The phone number listed below can be used to contact us to obtain coverage information, to obtain assistance in resolving complaints and for other inquiries you and your certificate holders may have. The toll free phone number is as follows:

1-800-660-1306

IMPORTANT POLICYHOLDER NOTICE

DRUG-FREE WORKPLACE PREMIUM DISCOUNT

In accordance with Florida Insurance Code Section 627.0915, we are notifying you that a drug-free workplace premium discount is available if you utilize a drug-free workplace plan pursuant to Florida Insurance Code Section 440.102 and the rules adopted under that section.

Premium will be reduced by 5% for an employer who has certified that it has established a drug-free workplace in accordance with rules as established by the Agency for Health Care Administration.

Certification is required for each year a premium credit is permitted.

The policy is subject to additional premium, for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that the policyholder misrepresented its compliance with the drug-free workplace rules.

IMPORTANT POLICYHOLDER NOTICE

COMPANY CONTACT INFORMATION - MISSOURI

We are required to provide you with our name, address and telephone number. For your convenience, please see the contact information listed below:

MEMIC
PO Box 11409
Portland, ME 04104

800-660-1306

IMPORTANT POLICYHOLDER NOTICE

LOSS CONTROL SERVICES IN MISSOURI

We are required to notify our policyholders that we provide loss control services. Loss control services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services.

If you would like more information or to request accident prevention services, contact our Loss Control Department:

MEMIC
P.O. Box 11409
Portland, Maine 04104
(800) 660-1306
losscontrolservice@memic.com

Additionally, the Missouri Division of Workers' Compensation offers free safety services to Missouri emplo--yers through its Missouri Workers' Safety Program (MWSP). The Division also certifies Missouri insurance carriers' safety engineering and management programs, which are available to policyholders upon request. Employers may contact MWSP at 1 (800) 775-COMP, (573) 526-5757, or mwsp@labor.mo.gov for more information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

IMPORTANT POLICYHOLDER NOTICE

ACCIDENT PREVENTION SERVICES

We are required to notify policyholders that accident prevention services are available at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services.

If you would like more information or to request accident prevention services, contact our Loss Control Department:

MEMIC
P.O. Box 11409
Portland, Maine 04104
(800) 660-1306
losscontrolservice@memic.com

(Ed. 05-14)

IMPORTANT POLICYHOLDER NOTICE

PAYMENT OF MEDICAL SERVICES ON NONDISABLING CLAIMS - OREGON

If you have operations in the state of Oregon, you may choose to reimburse us for medical services on accepted nondisabling claims up to certain amounts. Under ORS 656.262(5) the Director will establish the maximum reimbursable amount for medical services.

The costs of medical services for nondisabling claims must first be paid by us. You may then reimburse us if you choose. Such choice does not relieve you of your claim reporting duties.

When you reimburse us, such costs cannot be used to affect your experience rating modification or otherwise be charged against you.

The method and manner of reimbursement by you shall be as indicated below, however; in no case shall you have less than 30 days to reimburse us. If you wish to make such reimbursement, and so advise us in writing, the procedure for reimbursement shall be:

(A) Within 30 days following each three month period after policy inception or a period mutually agreed upon by yourself and us, we must provide you with a list of all accepted nondisabling claims for which payments were made during that period and the respective cost of each claim.

(B) No later than 30 days after receipt of this list, you must identify the claims and the dollar amount you wish to pay for that period and reimburse us accordingly.

(C) Failure by you to reimburse us within 30 days shall be deemed notice to us that you do not wish to make a reimbursement for that period.

(D) Notwithstanding section (B) above, we may, by mutual written agreement, establish a period in excess of thirty (30) days for you to reimburse us.

(E) We shall continue to bill you for any payments made on the claims within 27 months of the inception of the policy period. Any further billing and reimbursement will be made only by mutual agreement.

If your policy is written on a retrospective rating plan, medical costs paid by you on nondisabling claims must be included in the retrospective premium calculation, but the amount paid by you shall be applied as credits against the resulting retrospective premium.

If a claim changes from a nondisabling to a disabling claim and we have recovered reimbursement from you for medical costs billed by us prior to the change, we shall exclude those amounts reimbursed from your experience rating, or other individual or group rating plans you may have.

If you provide us with your written election to participate in the reimbursement program, such election remains in effect, without further notice from us, until you otherwise advise us in writing or you are no longer insured by us.

Please note that you are choosing to not participate in this program if you do not respond to us in writing within 30 days of receipt of this notice. However, you may participate later in the policy period upon written request to us, but the earliest reimbursement period shall be the first completed period, established under subsection (A) above, following receipt of your request.

Please contact your agent if you have any questions.

(Ed. 05-14)

IMPORTANT POLICYHOLDER NOTICE

OREGON INSURANCE GUARANTY ASSOCIATION ASSESSMENT

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 “Oregon Insurance Guaranty Association Assessment” along with an indicated dollar amount will be displayed with the statement of your surcharge.

(Ed. 05-14)

IMPORTANT POLICYHOLDER NOTICE

LOSS PREVENTION SERVICES IN OREGON

We are required to notify Oregon policyholders that loss prevention services are available. These services may include evaluation of loss prevention needs; assistance evaluating records pertinent to illness and injury experience; an explanation of the Oregon Safe Employment Act ("Act") and rules that apply to the particular place of employment; the provision of on-site health and safety surveys; assistance with industrial hygiene and safety evaluations; assistance evaluating, obtaining and maintaining personal protective equipment; evaluation of work practices, workplace design and assistance with job site modifications; assistance in evaluating and improving an employer's safety management practices; assistance in identifying health and safety training needs and resources; and follow-up services. We can also assist you in developing a loss prevention plan.

If you would like more information or to request accident prevention services, including and on-site evaluation of loss prevention service needs, contact our Loss Control Department:

MEMIC
P.O. Box 11409
Portland, Maine 04104
(800) 660-1306
losscontrolservice@memic.com

If we fail to respond to a request or to adequately provide services, you have the right to make a complaint to the OR-OSHA Division.

We are also required to explain your responsibility under the Act to provide a safe and healthful workplace. The Act states that you must do everything reasonably necessary to protect the life, safety and health of employees, including to furnish and use devices and safeguards and to adopt and use practices, means, methods, operations and processes as are reasonably necessary to render employment safe and healthful.

IMPORTANT POLICYHOLDER NOTICE
FOR POLICYHOLDERS WITH EXPOSURE IN TEXAS

To obtain information or make a complaint:

You may call our toll-free telephone number for information or to make a complaint at

1-800-660-1306

You may also write to us at:

MEMIC
PO Box 11409
Portland, ME 04104

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

800-578-4677

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX : 512-676-6000

PREMIUM OR CLAIMS DISPUTES

Should you have a dispute concerning your premium or about a claim you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY

This notice is for information only and does not become a part or condition of the attached document.

(Ed. 11-17)

IMPORTANT POLICYHOLDER NOTICE

ACCIDENT PREVENTION SERVICES AND RETURN-TO-WORK COORDINATION SERVICES FOR POLICYHOLDERS WITH EXPOSURE IN TEXAS

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

MEMIC Indemnity 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 MEMIC Indemnity at 800-660-1306 and losscontrolservice@memic.com for accident prevention services or 800-660-1306 and losscontrolservice@memic.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 MEMIC Indemnity fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to:

Texas Department of Insurance
Division of Workers' Compensation, MS-8
7551 Metro Center Drive
Austin, TX 78744-1645

IMPORTANT POLICYHOLDER NOTICE

RETURN-TO-WORK REIMBURSEMENT PROGRAM FOR POLICYHOLDERS WITH EXPOSURE IN TEXAS

In accordance with Texas Labor Code § 413.022, employers in Texas may be eligible for reimbursement or an advance under the Return-To-Work Reimbursement Program for the cost of providing workplace modifications to facilitate an injured employee's return to modified or alternative work following an injury. Complete details regarding the Return-to-Work Reimbursement Program may be found at the following website: http://www.tdi.texas.gov/wc/rtw/index.html.

An employer in Texas is eligible to apply for reimbursement or an advance under the Return-to-Work Reimbursement Program if:

a) The employer employs at least two but not more than fifty employees on each business day of the preceding calendar year;

b) The employer's workers' compensation insurance is currently in effect and was in effect on the date of the injury; and

c) The employer is not an agency of the State of Texas or a political subdivision of the state.

For more information about the Return-to-Work Reimbursement Program for Employers call the TDIDWCat (512) 804-5000 or email: rtw.services@tdi.texas.gov

IMPORTANT POLICYHOLDER NOTICE

INSTALLMENT FEE NOTICE - WISCONSIN

There will be a $5 installment fee for each and every installment bill issued for this policy. The installment fee will not apply to the initial deposit or to audit bills.

Please note that nonpayment of the installment fee(s) may result in the nonrenewal of your policy and/or appropriate legal action.

DEDUCTIBLE NOTICE OF ELECTION

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

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

If a deductible amount is desired, please indicate below.

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

1. $______________________________ per accident
2. $______________________________ per claim
3. $______________________________ medical-only

applied to benefits payable under the Texas Workers Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement ________________________________.
(monthly, quarterly or other)

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

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

____

The deductible plans have been explained to me.

Signature and Title		Date
Employer Name (print or type)		Address
Insurance Company	Policy No.	Effective Date

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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.

Form 54-2
(Ed. 3-13)

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OKLAHOMA WORKERS COMPENSATION MANDATORY OPTIONAL DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires carriers 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.

All five deductible options set forth below must 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 (medical benefits and indemnity claims) deductible amount. Medical-only claims are included in the eligibility for a combined medical and indemnity deductible. The maximum combined deductible, including medical benefits and indemnity claims, will be $5,000 per claim. Please carefully review the requirements for the deductible options outlined below.

DEDUCTIBLE OPTIONS

The combined optional deductible amounts are:

- $1,000
- $2,000
- $3,000
- $4,000
- $5,000

EMPLOYER OBLIGATIONS IF A DEDUCTIBLE OPTION IS SELECTED

If the applicant employer chooses a deductible, the carrier must 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 carrier within 60 days of a written demand. If the insured employer fails to reimburse the carrier within 60 days, the carrier may seek to recover the full amount of the claim from the insured employer. In addition, the nonpayment of deductible amounts must be treated in the same manner as nonpayment of premium for purposes of cancellation of the policy.

EXPERIENCE RATING MODIFICATION

Benefits paid by the insured employer under a deductible may not be treated as benefits paid so as to harm the experience rating of the employer, and will not be charged against the experience of the employer in accordance with OAC 365:15-1-3.1(d).

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.

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MEDICAL AND INDEMNITY

☐ $1,000

☐ $2,000

☐ $3,000

☐ $4,000

☐ $5,000

ACCEPTANCE/REJECTION

☐ 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.

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MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
310 2805098	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	

Renewal of	Transaction
Renewal of 310 2805098	RENEWAL DECLARATION

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier #	FEIN #:	Risk ID #	Unemployment ID #	Entity of Insured
38563	016000769	SEE EXT OF INFO		CORPORATION

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address
3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: AZ, AK, AR, CO, DC, DE, GA, HI, IA, ID, IN, KY, LA, MI, MO, MT, NC, NE, NM, NV, OK, OR, SD, TX, UT, WI

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here.
   AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

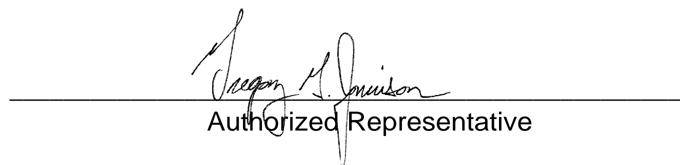
   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

SEE EXTENSION OF INFORMATION PAGE

Minimum Premium	$	315	**Total Estimated Annual Premium**	$	4,386
			Expense Constant	$	220
			Deposit Premium	$	4,386
Assessments and Taxes	$	60			

Countersigned this day of
Issued Date: 10/01/2020
Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551



Authorized Representative

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ARIZONA					
LOC: 00001 ADDRESS: 123 EL CAMINO REAL PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	23,746.00	0.330000	$	78
	MANUAL PREMIUM			**$**	**78**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	78.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	79.00	0.680000	$	-25
9740	TERRORISM	23,746.00	0.010000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	23,746.00	0.010000	$	2
	STATE TOTAL			**$**	**58**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ARKANSAS					
LOC: 00002 ADDRESS: 1108 EVERGREEN LANE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	10,881.00	0.290000	$	32
	MANUAL PREMIUM			**$**	**32**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	32.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	32.00	0.680000	$	-10
9740	TERRORISM	10,881.00	0.007000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	10,881.00	0.010000	$	1
	STATE TOTAL			**$**	**24**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
COLORADO					
LOC: 00003 ADDRESS: 8083 AMMONS WAY PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	85,997.00	0.540000	$	464
	MANUAL PREMIUM			**$**	**464**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	464.00	0.011000	$	5
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	469.00	0.680000	$	-150
9887	SCHEDULE CREDIT	319.00	0.100000	$	-32
9740	TERRORISM	85,997.00	0.008000	$	7
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	85,997.00	0.020000	$	17
	STATE TOTAL			**$**	**311**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
DELAWARE					
LOC: 00004 ADDRESS: 800 N FRENCH STREET PERIOD: 10/01/2020 TO 10/01/2021					
965	COLLEGE OR SCHOOL NOC - ALL EMPLOYEES INCLUDING OFFICE EXCEPT WORKFARE PROGRAM EMPLOYEES AND SEPARATELY LOCATED AND STAFFED PUBLIC LIBRARIES	* IF ANY *	0.580000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9885	MERIT RATING CREDIT		0.950000	$	0
9740	TERRORISM		0.013000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$	0
	STATE TOTAL			**$**	

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
DISTRICT OF COLUMBIA					
LOC: 00005 ADDRESS: 5TH STREET NW					
PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	82,922.00	0.280000	$	232
	MANUAL PREMIUM			**$**	**232**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	232.00	0.011000	$	3
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	235.00	0.680000	$	-75
9740	TERRORISM	82,922.00	0.109000	$	90
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	82,922.00	0.020000	$	17
DC SRG	WORKERS COMPENSATION POLICY HOLDER SURCHARGE	267.00	0.000000	$	0
	STATE TOTAL			**$**	**267**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
GEORGIA					
LOC: 00007 ADDRESS: 55 TRINTY AVE SW PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	74,337.00	0.430000	$	320
	MANUAL PREMIUM			**$**	**320**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	320.00	0.011000	$	4
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	324.00	0.680000	$	-104
9740	TERRORISM	74,337.00	0.009000	$	7
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	74,337.00	0.020000	$	15
	STATE TOTAL			**$**	**242**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
IDAHO				
LOC: 00008 ADDRESS: 1632 S RIVERSTONE LANE APT 203 PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	63,776.00	0.620000	$ 395
	MANUAL PREMIUM			**$ 395**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	395.00	0.011000	$ 4
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	399.00	0.680000	$ -128
9740	TERRORISM	63,776.00	0.010000	$ 6
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	63,776.00	0.010000	$ 6
	STATE TOTAL			**$ 283**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
INDIANA					
LOC: 00009 ADDRESS: 6422 RALSTON AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,000.00	0.290000	$	9
	MANUAL PREMIUM			**$**	**9**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	9.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	9.00	0.680000	$	-3
9740	TERRORISM	3,000.00	0.010000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,000.00	0.010000	$	0
0935	SECOND INJURY FUND ASSESSMENT	6.00	0.008300	$	0
	STATE TOTAL			**$**	**6**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

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

LOC: 00010 ADDRESS: 815 PINON DRIVE #212
PERIOD: 10/01/2020 TO 10/01/2021

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	19,400.00	0.490000	$	95
	MANUAL PREMIUM			**$**	**95**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	95.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	96.00	0.680000	$	-31
9740	TERRORISM	19,400.00	0.010000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	19,400.00	0.010000	$	2
	STATE TOTAL			**$**	**69**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
KENTUCKY					
LOC: 00011 ADDRESS: 3840 NADIA LANE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,852.00	0.240000	$	9
	MANUAL PREMIUM			**$**	**9**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	9.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	9.00	0.680000	$	-3
9740	TERRORISM	3,852.00	0.006000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,852.00	0.010000	$	0
KY SRG	KENTUCKY WORKERS COMPENSATION SURCHARGE	6.00	0.064100	$	0
	STATE TOTAL			**$**	**6**

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
LOUISIANA				
LOC: 00012 ADDRESS: 408 KEES CIRCLE PERIOD: 10/01/2020 TO 10/01/2021				
8868	ARCHAELOGIST RESEARCH	* IF ANY *	0.490000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.014000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
9740	TERRORISM		0.007000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$ 0
	STATE TOTAL			**$**

MEMIC Indemnity Company
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Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MICHIGAN					
LOC: 00013 ADDRESS: 3477 CLAY ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE-PROFESSIONAL EMPLOYEES	117,645.00	0.290000	$	341
	MANUAL PREMIUM			**$**	**341**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	341.00	0.020000	$	7
9740	TERRORISM ACT SURCHARGE	117,645.00	0.032000	$	38
	STATE TOTAL			**$**	**386**

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EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MISSOURI					
LOC: 00015 ADDRESS: 2017 YORKTOWN DRIVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,852.00	0.570000	$	22
	MANUAL PREMIUM			**$**	**22**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	22.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	22.00	0.680000	$	-7
9740	TERRORISM	3,852.00	0.008000	$	0
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	15.00	0.030000	$	0
MO SSS	MO SIF SUPPLEMENTAL SCHG	15.00	0.020000	$	0
	STATE TOTAL			**$**	**15**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MONTANA					
LOC: 00014 ADDRESS: 3845 VINAL LAKE ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	18,850.00	0.770000	$	145
	MANUAL PREMIUM			**$**	**145**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	145.00	0.011000	$	2
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	147.00	0.680000	$	-47
9740	TERRORISM	18,850.00	0.009000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	18,850.00	0.020000	$	4
0935	MONTANA SECOND INJURY FUND SURCHARGE	106.00	0.004368	$	0
0934	STAY-AT-WORK/RETURN-TO-WORK SURCHARGE	106.00	0.000000	$	0
0939	WC REGULATORY ASSESSMENT SURCHARGE	106.00	0.016159	$	2
9616	MT OCC S&H REG ASSESSMENT SRG	106.00	0.008076	$	1
	STATE TOTAL			**$**	**109**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEBRASKA					
LOC: 00035 ADDRESS: 2411 THIRD AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8,616.00	0.330000	$	28
	MANUAL PREMIUM			**$**	**28**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	28.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	28.00	0.680000	$	-9
9740	TERRORISM	8,616.00	0.006000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	8,616.00	0.010000	$	1
	STATE TOTAL			**$**	**21**

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EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEVADA					
LOC: 00030 ADDRESS: 4181 BROOKVIEW WAY PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	6,136.00	0.610000	$	37
	MANUAL PREMIUM			**$**	**37**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	37.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	37.00	0.680000	$	-12
9740	TERRORISM	6,136.00	0.058000	$	4
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	6,136.00	0.010000	$	1
	STATE TOTAL			**$**	**30**

MEMIC Indemnity Company
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Policy Number: 310 2805098
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEW MEXICO					
LOC: 00016 ADDRESS: 3939 RIO GRAND BLVD NW #7 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM		0.008000	$	0
	STATE TOTAL			**$**	

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NORTH CAROLINA					
LOC: 00017 ADDRESS: 1400 CENTRAL AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	35,923.00	0.260000	$	93
	MANUAL PREMIUM			**$**	**93**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	93.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	94.00	0.680000	$	-30
9740	TERRORISM	35,923.00	0.006000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	35,923.00	0.010000	$	4
	STATE TOTAL			**$**	**70**

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MEMIC Indemnity Company
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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
OKLAHOMA					
LOC: 00018 ADDRESS: 722 N PORTER AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.014000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM		0.008000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.020000	$	0
	STATE TOTAL			**$**	

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
OREGON					
LOC: 00019 ADDRESS: 20025 SILVER FALLS HWY SE PERIOD: 10/01/2020 TO 10/01/2021					
8868	SCHOOLS- PROFESSIONAL & CLERICAL	9,066.00	0.340000	$	31
	MANUAL PREMIUM			**$**	**31**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	31.00	0.004000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	31.00	0.680000	$	-10
9740	TERRORISM	9,066.00	0.008000	$	1
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	9,066.00	0.020000	$	2
OR SRG	OREGON WORKERS COMPENSATION SURCHARGE	24.00	0.084000	$	2
OR IGA	OREGON INSURANCE GUARANTEE ASSOCIATION	24.00	0.000000	$	0
	STATE TOTAL			**$**	**26**

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CLASSIFICATION OF OPERATIONS

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

LOC: 00034 ADDRESS: 503 WEST APPLE ST
PERIOD: 10/01/2020 TO 10/01/2021

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	3,927.00	0.420000	$	16
	MANUAL PREMIUM			**$**	**16**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	16.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	16.00	0.680000	$	-5
9740	TERRORISM	3,927.00	0.008000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	3,927.00	0.020000	$	1
SDPS	SOUTH DAKOTA POLICYHOLDER SURCHARGE		0.000000	$	14
	STATE TOTAL			**$**	**26**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
TEXAS				
LOC: 00020 ADDRESS: 703 E 3RD ST PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	240,231.00	0.280000	$ 673
	MANUAL PREMIUM			**$ 673**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	673.00	0.014000	$ 9
9848	TO EQUAL MINIMUM PREMIUM (E L)		0.000000	$ 91
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	773.00	0.680000	$ -247
9740	TERRORISM ACT SURCHARGE	240,231.00	0.024000	$ 58
	STATE TOTAL			**$ 584**

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Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
UTAH					
LOC: 00023 ADDRESS: 112E BROADWAY PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	21,960.00	0.220000	$	48
	MANUAL PREMIUM			**$**	**48**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	48.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	49.00	0.680000	$	-16
9740	TERRORISM	21,960.00	0.008000	$	2
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	21,960.00	0.020000	$	4
	STATE TOTAL			**$**	**39**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
WISCONSIN				
LOC: 00024 ADDRESS: 2 S PINCKNEY STREET PERIOD: 10/01/2020 TO 10/01/2021				
8868	SCHOOL: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.530000	$ 0
	MANUAL PREMIUM			**$ 0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$ 0
0900	EXPENSE CONSTANT			$ 220
9740	TERRORISM		0.020000	$ 0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$ 0
	STATE TOTAL			**$ 220**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
HAWAII					
LOC: 00021 ADDRESS: 2272 KALAKAUA AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.640000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM		0.015000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$	0
	STATE TOTAL			**$**	

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ALASKA					
LOC: 00022 ADDRESS: 4732 OMALLY ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	* IF ANY *	0.830000	$	0
	MANUAL PREMIUM			**$**	**0**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)		0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)		0.680000	$	0
9740	TERRORISM ACT SURCHARGE		0.007000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)		0.010000	$	0
AK INS	AK INS GUARANTY ASSOC		0.005000	$	0
	STATE TOTAL			**$**	
	POLICY TOTAL			**$**	**4,386**

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00001	UNIVERSITY OF MAINE SYSTEM	123 EL CAMINO REAL SEDONA AZ 85201-0000	
00025	UNIVERSITY OF MAINE SYSTEM	4580 N VIA MADRE TUCSON AZ 85749-0000	
00002	UNIVERSITY OF MAINE SYSTEM	1108 EVERGREEN LANE BLYTHEVILLE AR 72315-0000	
00003	UNIVERSITY OF MAINE SYSTEM	8083 AMMONS WAY ARVADA CO 75011-0000	
00004	UNIVERSITY OF MAINE SYSTEM	800 N FRENCH STREET WILMINGTON DE 19801-0000	
00005	UNIVERSITY OF MAINE SYSTEM	5TH STREET NW WASHINGTON DC 20001-0000	
00007	UNIVERSITY OF MAINE SYSTEM	55 TRINTY AVE SW ATLANTA GA 30303-0000	
00008	UNIVERSITY OF MAINE SYSTEM	1632 S RIVERSTONE LANE APT 203 BOISE ID 83701-0000	
00009	UNIVERSITY OF MAINE SYSTEM	6422 RALSTON AVE INDIANAPOLIS IN 47512-0000	
00010	UNIVERSITY OF MAINE SYSTEM	815 PINON DRIVE #212 AMES IA 50010-0000	
00011	UNIVERSITY OF MAINE SYSTEM	3840 NADIA LANE LEXINGTON KY 40514-0000	
00012	UNIVERSITY OF MAINE SYSTEM	408 KEES CIRCLE LAFAYETTE LA 70501-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00013	UNIVERSITY OF MAINE SYSTEM	3477 CLAY ROAD ROTHBURY MI 49452-0000	
00014	UNIVERSITY OF MAINE SYSTEM	3845 VINAL LAKE ROAD TROY MT 59935-0000	
00015	UNIVERSITY OF MAINE SYSTEM	2017 YORKTOWN DRIVE CAPE GIRARDEAU MO 63701-0000	
00016	UNIVERSITY OF MAINE SYSTEM	3939 RIO GRAND BLVD NW #7 ALBUQUERQUE NM 87107-0000	
00017	UNIVERSITY OF MAINE SYSTEM	1400 CENTRAL AVE CHARLOTTE NC 28205-0000	
00018	UNIVERSITY OF MAINE SYSTEM	722 N PORTER AVE NORMAN OK 73071-0000	
00019	UNIVERSITY OF MAINE SYSTEM	20025 SILVER FALLS HWY SE SUBLIMITY OR 97385-0000	
00020	UNIVERSITY OF MAINE SYSTEM	703 E 3RD ST TYLER TX 75201-0000	
00021	UNIVERSITY OF MAINE SYSTEM	2272 KALAKAUA AVE HONOLULU HI 96815-0000	UIAN: 0199999999
00022	UNIVERSITY OF MAINE SYSTEM	4732 OMALLY ROAD ANCHORAGE AK 99507-0000	
00023	UNIVERSITY OF MAINE SYSTEM	112E BROADWAY SALT LAKE CITY UT 84111-0000	UIAN: 0199999
00024	UNIVERSITY OF MAINE SYSTEM	2 S PINCKNEY STREET MADISON WI 53703-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00026	UNIVERSITY OF MAINE SYSTEM	511 DIRKSEN SENATE BLDG WASHINGTON DC 20001-0000	
00027	UNIVERSITY OF MAINE SYSTEM	100 INDEPENDENCE AVE SW WASHINGTON DC 20001	
00028	UNIVERSITY OF MAINE SYSTEM	1244 G STREET NE WASHINGTON DC 20001-0000	
00030	UNIVERSITY OF MAINE SYSTEM	4181 BROOKVIEW WAY LAS VEGAS NV 89121	
00034	UNIVERSITY OF MAINE SYSTEM	503 WEST APPLE ST PARKSTON SD 57366	
00035	UNIVERSITY OF MAINE SYSTEM	2411 THIRD AVE SCOTTSBLUFF NE 69361	

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NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM	CORPORATION	016000769

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
AZ	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AZ	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AZ	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AZ	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AZ	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AZ	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
AZ	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AZ	WC020601A	(9/15)	AZ CANCELLATION & NONRENEWAL
AR	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AR	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AR	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AR	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
AR	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AR	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AR	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
AR	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AR	WC030601B	(3/18)	AR AMENDATORY ENDORSEMENT
AR	WC990403	(7/11)	INSTALLMENT FEE
CO	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
CO	WC000404	(4/84)	PENDING RATE CHANGE ENDT
CO	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
CO	WC000419	(1/01)	PREMIUM DUE DATE ENDT
CO	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
CO	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
CO	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
CO	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
CO	WC050402	(11/90)	CLASSIFICATION ENDT
CO	WC050403	(3/93)	PREM CREDIT FOR CERTIFIED RISK
CO	WC990403	(7/11)	INSTALLMENT FEE
DE	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
DE	WC000404	(4/84)	PENDING RATE CHANGE ENDT
DE	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT

MEMIC Indemnity Company
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650 Elm Street Suite 401
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Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
DE	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
DE	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
DE	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
DE	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
DE	WC070408	(7/99)	DE MERIT RATING PLAN ENDORSMNT
DE	WC070601	(7/88)	DE NONRENEWAL ENDT
DE	WC990403	(7/11)	INSTALLMENT FEE
DC	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
DC	WC000404	(4/84)	PENDING RATE CHANGE ENDT
DC	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
DC	WC000419	(1/01)	PREMIUM DUE DATE ENDT
DC	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
DC	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
DC	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
DC	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
DC	WC080601	(4/84)	DC CANCELLATION ENDT
DC	WC990403	(7/11)	INSTALLMENT FEE
GA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
GA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
GA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
GA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
GA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
GA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
GA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
GA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
GA	WC100601C	(7/18)	GA CANC,NON-RENEWAL & RN ENDT
GA	WC990403	(7/11)	INSTALLMENT FEE
ID	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
ID	WC000404	(4/84)	PENDING RATE CHANGE ENDT
ID	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
ID	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
ID	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
ID	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
ID	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
ID	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
ID	WC990403	(7/11)	INSTALLMENT FEE
IN	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
IN	WC000404	(4/84)	PENDING RATE CHANGE ENDT

MEMIC Indemnity Company
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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
IN	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
IN	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
IN	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
IN	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
IN	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
IN	WC990403	(7/11)	INSTALLMENT FEE
IA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
IA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
IA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
IA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
IA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
IA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
IA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
IA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
IA	WC990403	(7/11)	INSTALLMENT FEE
KY	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
KY	WC000404	(4/84)	PENDING RATE CHANGE ENDT
KY	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
KY	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
KY	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
KY	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
KY	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
KY	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
KY	WC160305	(6/07)	KY PART ONE W/C INS ENDT
KY	WC160601	(12/97)	KY CANCELATION/NONRENEWAL ENDT
KY	WC160602	(10/99)	KY NOTICE OF APPEAL RIGHTS
KY	WC990403	(7/11)	INSTALLMENT FEE
LA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
LA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
LA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
LA	WC000419	(1/01)	PREMIUM DUE DATE ENDT
LA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
LA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
LA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
LA	WC170303	(12/00)	DUTY TO DEFEND ENDT
LA	WC170601J	(8/18)	LA AMENDATORY ENDORSEMENT
LA	WC170602A	(2/96)	COST CONTAINMENT ACT
LA	WC990403	(7/11)	INSTALLMENT FEE

MEMIC Indemnity Company
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Workers Compensation and Employers Liability Insurance Policy

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Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
MI	WC210303A	(6/97)	MI NOTICE TO POLICYHOLDER ENDT
MI	WC210304	(4/84)	MI LAW ENDORSEMENT
MI	WC990403	(7/11)	INSTALLMENT FEE
MI	WC990655	(1/14)	MICHIGAN DISCLAIMER
MO	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MO	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MO	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
MO	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MO	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MO	WC240302	(1/14)	ADD'L MESOTHELIOMA BENEFITS
MO	WC240601B	(1/96)	MO CANC/NRN ENDT
MO	WC240602B	(7/06)	MO PROP & CAS GUARANTY ASSOC
MO	WC240604C	(9/19)	MISSOURI AMENDATORY END
MO	WC990403	(7/11)	INSTALLMENT FEE
MT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MT	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MT	WC000419	(1/01)	PREMIUM DUE DATE ENDT
MT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
MT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MT	WC250305	(7/02)	INTENTIONAL INJURY EXCL
MT	WC250401A	(1/17)	MONTANA AUDIT NONCOMPLIANCE
MT	WC250601B	(4/16)	MT AMENDATORY ENDORSEMENT
MT	WC250602	(1/94)	SAFETY ENDT
MT	WC990403	(7/11)	INSTALLMENT FEE
NE	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NE	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NE	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NE	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NE	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NE	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NE	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NE	WC260401B	(5/17)	NE EXP RATING MOD FACTOR

Issued Date: 10/01/2020

MEMIC Indemnity Company
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650 Elm Street Suite 401
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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NE	WC260403	(5/17)	NE EXP RATING MOD FACTOR REV
NE	WC260601C	(7/96)	NE CANCELLATION ENDT
NE	WC990403	(7/11)	INSTALLMENT FEE
NV	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NV	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NV	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NV	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NV	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NV	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NV	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NV	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NV	WC270601C	(10/08)	NV CANCELATION/NONRENEWAL ENDT
NV	WC990403	(7/11)	INSTALLMENT FEE
NM	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NM	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NM	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NM	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NM	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NM	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NM	WC300601A	(3/15)	NM CANC AND NONRENEWAL ENDT
NM	WC990403	(7/11)	INSTALLMENT FEE
NC	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NC	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NC	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NC	WC000419	(1/01)	PREMIUM DUE DATE ENDT
NC	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NC	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NC	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NC	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NC	WC320301D	(7/18)	NC AMENDED COVERAGE ENDT
NC	WC320602	(1/10)	PRO-RATA CANCEL ENDT
NC	WC990403	(7/11)	INSTALLMENT FEE
OK	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
OK	WC000404	(4/84)	PENDING RATE CHANGE ENDT
OK	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
OK	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
OK	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
OK	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT

MEMIC Indemnity Company
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650 Elm Street Suite 401
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Policy Number: 310 2805098
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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
OK	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
OK	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
OK	WC350302	(1/87)	OK EMPL LIABILITY AMENDED COV
OK	WC350303	(3/11)	OK EL INTENTIONAL TORT EXCL
OK	WC350601F	(2/14)	OK CN,NONRENEWAL & CHG ENDT
OK	WC350603	(12/93)	OK FRAUD WARNING ENDT
OK	WC990407	(7/14)	INSTALLMENT FEE
OR	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
OR	WC000404	(4/84)	PENDING RATE CHANGE ENDT
OR	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
OR	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
OR	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
OR	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
OR	WC360404A	(5/17)	OR GROUP SUPPLEMNT RTG END
OR	WC360406	(10/01)	OR PREMIUM DUE DATE ENDMNT
OR	WC360601E	(1/08)	OR CANCELLATION ENDMNT
OR	WC360604	(1/17)	OR AMENDATORY ENDORSEMENT
OR	WC990403	(7/11)	INSTALLMENT FEE
SD	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
SD	WC000404	(4/84)	PENDING RATE CHANGE ENDT
SD	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
SD	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
SD	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
SD	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
SD	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
SD	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
SD	WC400601A	(7/11)	SD DIRECT ACTION STATUTE
SD	WC400603	(1/94)	SD MANAGED CARE ENDMNT
SD	WC400605B	(4/06)	SD CANCELLATION AND NONRENEW
SD	WC990403	(7/11)	INSTALLMENT FEE
TX	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
TX	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
TX	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
TX	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
TX	WC420301J	(6/20)	TEXAS AMENDATORY ENDORSEMENT
TX	WC420407	(3/02)	TX AUDIT PREMIUM & RETROSPECT
UT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
UT	WC000404	(4/84)	PENDING RATE CHANGE ENDT

MEMIC Indemnity Company
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Policy Number: 310 2805098
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Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
UT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
UT	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
UT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
UT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
UT	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
UT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
UT	WC430602	(7/02)	UT CANCELLATION ENDORSEMENT
UT	WC990403	(7/11)	INSTALLMENT FEE
WI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
WI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
WI	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
WI	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
WI	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
WI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
WI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
WI	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
WI	WC480601C	(4/01)	WI LAW ENDT
WI	WC480606B	(1/02)	WI CANC/NRN ENDT
HI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
HI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
HI	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
HI	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
HI	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
HI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
HI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
HI	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
HI	WC520602	(1/96)	HI NOTIFICATION ENDT
HI	WC990403	(7/11)	INSTALLMENT FEE
AK	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
AK	WC000404	(4/84)	PENDING RATE CHANGE ENDT
AK	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
AK	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
AK	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
AK	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
AK	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
AK	WC540301	(4/95)	AK LIMIT OF LIABILITY ENDT
AK	WC540601A	(1/13)	AK NOTICE OF INSTALLMENT OP
AK	WC540602	(4/95)	AK CANCEL/NONRENEWAL ENDT

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Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
AK	WC990643	(1/13)	AK PAYMENT PLANS ENDT

Issued Date: 10/01/2020

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

POLICY NUMBER: 310 2805098

1. Named Insured and Address	Agent – For Informational Purposes Only
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier Code #	FEIN #:	Risk ID #	Type of Insured: ___ Individual ___ Partnership
38563	016000769	SEE EXT OF INFO	X Corporation or ______

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address
3. A. Workers Compensation Insurance: PART ONE of the policy applies to the Workers Compensation Law of the states listed here: FL

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

   C. Other States Insurance: PART THREE of the policy applies to the states, if any, listed here.
   AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

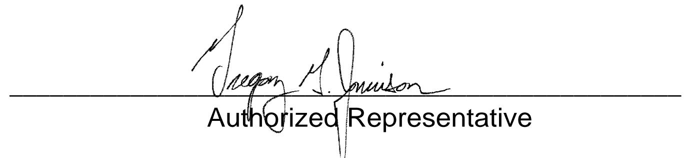
SEE EXTENSION OF INFORMATION PAGE FOR MORE DETAIL

Florida Workers Compensation Insurance Guaranty Association Surcharge: 1.0 %

Minimum Premium $ 315

Total Estimated Annual Premium $ 4,386
Expense Constant $ 220
Deposit Premium N/A in Florida

Countersigned this day of
Issued Date: 10/01/2020
Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551



Authorized Representative

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 4
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
FLORIDA					
LOC: 00006 ADDRESS: 177 JONES CREEK DRIVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	138,520.00	0.440000	$	609
	MANUAL PREMIUM			**$**	**609**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	609.00	0.014000	$	9
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	618.00	0.680000	$	-198
9740	TERRORISM	138,520.00	0.010000	$	14
FWCIGA	FL WC GUARANTY ASSOC SURCHARGE	434.00	0.010000	$	4
	STATE TOTAL			**$**	**438**

EXTENSION OF INFORMATION PAGE FOR ITEM 1
ADDITIONAL WORKPLACES SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00006	UNIVERSITY OF MAINE SYSTEM	177 JONES CREEK DRIVE JUPITER FL 30201-0000	
00029	UNIVERSITY OF MAINE SYSTEM	14317 LUCERNE DRIVE #G TAMPA FL 30201-0000	

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 1

NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM	CORPORATION	016000769

MEMIC Indemnity Company
A Stock Company
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM 3 D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
FL	WC000404	(4/84)	PENDING RATE CHANGE ENDT
FL	WC000406A	(7/95)	PREMIUM DISCOUNT ENDORSEMENT
FL	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
FL	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
FL	WC090303	(8/05)	FL EMPLOYERS LIAB COV ENDT
FL	WC090402A	(5/17)	FL EXP RATING MOD FACTOR
FL	WC090403B	(1/15)	TERRORISM RISK INS ACT ENDT
FL	WC090407	(7/13)	FL NON-COOP WITH PREMIUM AUDIT
FL	WC090408A	(7/19)	FLORIDA INSUFFICIENT FUNDS EN
FL	WC090606	(10/98)	FL EMPL & WAGE INFO RELEASE
FL	WC090607A	(7/19)	FL WC GUARANTY ASSOC SURCHARGE
FL	WC990678	(5/18)	EXECUTION CLAUSE

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance

POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
310 2805098	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	
Prior Policy Number	Renewal of 310 2805098	

Transaction - RENEWAL DECLARATION

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000
Email address:	Telephone: 207-947-7345

NCCI Carrier #	FEIN #:	Intra/Interstate Risk ID#	Entity of Insured
38563	016000769	SEE EXT OF INFO	___ Individual ___ Partnership X Corporation ___ LLC ___ LLP or Other___

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard Time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: CA

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

   Bodily Injury by Accident $1,000,000 Each accident
   Bodily Injury by Disease $1,000,000 Policy limit
   Bodily Injury by Disease $1,000,000 Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here.
   AL, CT, IL, KS, MA, MD, ME, MN, MS, NH, NJ, NY, PA, RI, SC, TN, VA, VT, WV,

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE.

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

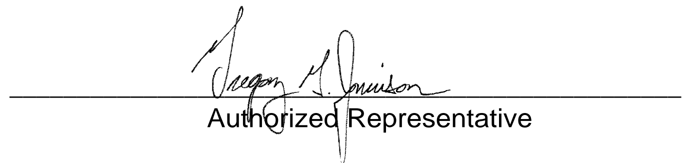
SEE EXTENSION OF INFORMATION PAGE

Minimum Premium	$	315
Experience Modification Factor		0.0
Assessments and Taxes	$	60
Total Estimated Annual Premium	$	4,386
Expense Constant	$	220
Deposit Premium	$	4,386

Countersigned this day of

Issued Date: 10/01/2020

Issuing Office: 650 Elm Street Suite 401
Manchester NH 03101-2551



Authorized Representative

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
CALIFORNIA					
LOC: 00031 ADDRESS: 811 LARKRIDGE STREET PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	103,317.00	1.020000	$	1,054
	MANUAL PREMIUM			**$**	**1,054**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	1,054.00	0.011000	$	12
9740	TERRORISM	103,317.00	0.031000	$	32
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	103,317.00	0.020000	$	21
CA AST	CALIFORNIA WORKERS COMPENSATION FRAUD ASSESSMENT FACTOR	1,119.00	0.003349	$	4
CA LEC	CA-LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT	1,119.00	0.003813	$	4
CA OSH	CA OCCUPATIONAL SAFETY & HEALTH FUND	1,119.00	0.003918	$	4
CA SIB	CALIFORNIA SUBSEQUENT INJURIES BENEFIT TRUST FUND ASSESSMENT	1,119.00	0.004829	$	5
CA SRG	CA WC ADMINISTRATION REVOLVING FUND ASSESSMENT	1,119.00	0.017040	$	19
CA UEB	CALIFORNIA UNINSURED EMPLOYERS BENEFIT TRUST FUND ASSESSMENT	1,119.00	0.001274	$	1
CIGAS	CALIFORNIA INSURANCE GUARANTEE ASSOCIATION SURCHARGE	1,119.00	0.000000	$	0
	STATE TOTAL			**$**	**1,156**

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM ONE
ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00031	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	811 LARKRIDGE STREET IRVINE CA 94201	
00032	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	11365 LAKE RIM ROAD SAN DIEGO CA 93201	
00033	UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	345 MIDDLEFIELD ROAD MENLO PARK CA 94201	

Issued Date: 10/01/2020

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Policy Number: 310 2805098	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM ONE

NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT	CORPORATION	016000769

MEMIC Indemnity Company
(A Stock Company)
650 Elm Street Suite 401
Manchester NH 03101-2551

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 310 2805098
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
US	WC340301C	(3/10)	OH EMPLOYERS LIAB COV ENDT
US	WC990327	(5/10)	WASHINGTON EL COV ENDT
US	WC990328	(4/11)	ND EL COVERAGE ENDORSEMENT
US	WC990336	(4/14)	WY EL COVERAGE ENDT
CA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
CA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
CA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
CA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
CA	WC040301D	(2/18)	POLICY AMENDATORY ENDT - CA
CA	WC040310	(1/95)	CA DUTY TO DEFEND
CA	WC040360B	(1/15)	CA EMPLOYERS LIAB COV ENDT
CA	WC040421	(1/08)	CA OPTIONAL PREMIUM INCREASE
CA	WC040422	(1/12)	CA SHORT RATE CANCELLATION
CA	WC040601A	(12/93)	CA CANCELLATION ENDT
CA	WC990403	(7/11)	INSTALLMENT FEE

Issued Date: 10/01/2020

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

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IMPORTANT This Quick Reference is **not** part of the Workers Compensation and Employers Liability Policy and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

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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

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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

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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.

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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

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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.

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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.

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NOTIFICATION ENDORSEMENT OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2015

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

The Terrorism Risk Insurance Act of 2002 (TRIA), as previously amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2015 (TRIPRA 2015), provides for a program under which the federal government will share in the payment of insured losses caused by certain acts of terrorism. In the absence of affirmative US Congressional action to extend, update, or otherwise reauthorize TRIPRA 2015, in whole or in part, TRIPRA 2015 is scheduled to expire on December 31, 2020.

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

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

The premium charge for the coverage that your policy provides for terrorism losses is shown in Item 4 of the policy Information Page or the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 B) Schedule that is attached to your policy. This amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2020, in the event of TRIPRA 2015's expiration, subject to regulatory review in accordance with applicable state law.

You need not do anything further at this time.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by ____________________

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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

ALASKA
ARKANSAS
ARIZONA
COLORADO
DISTRICT OF COLUMBIA
DELAWARE
FLORIDA
GEORGIA
HAWAII
IOWA
IDAHO
INDIANA
KENTUCKY
LOUISIANA
MICHIGAN
MONTANA
NORTH CAROLINA
NEBRASKA
NEVADA
OKLAHOMA
OREGON
SOUTH DAKOTA
UTAH
WISCONSIN

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ______________________________

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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**

State	First $10,000	Next $190,000	Next $1,550,000	Balance Over $1,750,000
FLORIDA	0.0%	9.1%	11.3%	12.3%

2. Average percentage discount: %

3. Other policies:

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

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

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

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

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
ARIZONA	0.010000	$2.00
ARKANSAS	0.010000	$1.00
CALIFORNIA	0.020000	$21.00
COLORADO	0.020000	$17.00
DELAWARE	0.010000	$0.00
DISTRICT OF COLUMBIA	0.020000	$17.00
GEORGIA	0.020000	$15.00
IDAHO	0.010000	$6.00
INDIANA	0.010000	$0.00
IOWA	0.010000	$2.00

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by______________________

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CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
KENTUCKY	0.010000	$0.00
LOUISIANA	0.010000	$0.00
MONTANA	0.020000	$4.00
NEBRASKA	0.010000	$1.00
NEVADA	0.010000	$1.00
NORTH CAROLINA	0.010000	$4.00
OKLAHOMA	0.020000	$0.00
OREGON	0.020000	$2.00
SOUTH DAKOTA	0.020000	$1.00
UTAH	0.020000	$4.00

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by____________________

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CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

For purposes of this endorsement, the following definitions apply:

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

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

Schedule

State	Rate	Premium
WISCONSIN	0.010000	$0.00
HAWAII	0.010000	$0.00
ALASKA	0.010000	$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____________________

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TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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

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

Definitions

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

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

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

a. The act is an act of terrorism.

b. The act is violent or dangerous to human life, property or infrastructure.

c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.

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

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

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

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.

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d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.

e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.

f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.

2. Notwithstanding item 1 above, the United States Government will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.

3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
ARIZONA	0.010000	$2.00
ARKANSAS	0.007000	$1.00
CALIFORNIA	0.031000	$32.00
COLORADO	0.008000	$7.00
DELAWARE	0.013000	$0.00
DISTRICT OF COLUMBIA	0.109000	$90.00
GEORGIA	0.009000	$7.00
IDAHO	0.010000	$6.00
INDIANA	0.010000	$0.00
IOWA	0.010000	$2.00
KENTUCKY	0.006000	$0.00
LOUISIANA	0.007000	$0.00
MICHIGAN	0.032000	$38.00
MISSOURI	0.008000	$0.00
MONTANA	0.009000	$2.00
NEBRASKA	0.006000	$1.00
NEVADA	0.058000	$4.00
NEW MEXICO	0.008000	$0.00
NORTH CAROLINA	0.006000	$2.00
OKLAHOMA	0.008000	$0.00
OREGON	0.008000	$1.00
SOUTH DAKOTA	0.008000	$0.00
TEXAS	0.024000	$58.00
UTAH	0.008000	$2.00
WISCONSIN	0.020000	$0.00
HAWAII	0.015000	$0.00
ALASKA	0.007000	$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 ____________________

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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
ARIZONA	Estimated Annual Premium	2.00
ARKANSAS	Estimated Annual Premium	2.00
COLORADO	Estimated Annual Premium	2.00
DELAWARE	Estimated Annual Premium	2.00
DISTRICT OF COLUMBIA	Estimated Annual Premium	2.00
GEORGIA	Estimated Annual Premium	2.00
IDAHO	Estimated Annual Premium	2.00
IOWA	Estimated Annual Premium	2.00
KENTUCKY	Estimated Annual Premium	2.00
MICHIGAN	Estimated Annual Premium	2.00
NEBRASKA	Estimated Annual Premium	2.00
NEVADA	Estimated Annual Premium	1.00
NEW MEXICO	Estimated Annual Premium	2.00
NORTH CAROLINA	Estimated Annual Premium	3.00
OKLAHOMA	Estimated Annual Premium	2.00

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________

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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
OREGON	Estimated Annual Premium	2.00
SOUTH DAKOTA	Estimated Annual Premium	2.00
UTAH	Estimated Annual Premium	2.00
WISCONSIN	Estimated Annual Premium	1.00
HAWAII	Estimated Annual Premium	2.00

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by ______________________

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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 ______________________

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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.
4. If we cancel or nonrenew this policy, we must mail or deliver to you and the Industrial Commission of Arizona at least 30 days' notice of the cancellation or nonrenewal. 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 nonrenew this policy and fail to give you notice of nonrenewal, coverage will not extend beyond the policy period.
5. The policy period will end on the day and hour stated in the cancellation or nonrenewal 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 ______________________________

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ARKANSAS AMENDATORY ENDORSEMENT

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

Part Two—Employers Liability Insurance, Section C. (Exclusions), Item 2 of the policy is replaced by the following:

2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law; punitive or exemplary damages are defined by Arkansas Bulletin No. 4-82 as those damages which are imposed to punish a wrongdoer and to deter others from similar conduct;

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 at least 30 days' advance written notice of cancellation to us. Cancellation is effective at 12:01 a.m. 30 days after we receive notice unless you specify a later date for cancellation.

   You may cancel coverage effective less than 30 days after written notice has been received by us if you have obtained other coverage or become a self-insurer.

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 and to the Arkansas Workers Compensation Commission not less than 10 days advance written notice stating when the cancellation is to take effect. If we cancel for any other reason, we will mail or deliver to you and to the Arkansas Workers Compensation Commission not less than 30 days' advance written notice stating when the cancellation is to take effect. Mailing notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient notice.

3. The policy period will end on the day and hour stated in the cancellation 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 ____________________

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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.

Note:

1. This endorsement may be used to amend the Workers Compensation and Employers Liability Insurance Policy, WC 00 00 00 C, to comply with California 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 | Insurance Company

Countersigned By ______________________________

DUTY TO DEFEND – CALIFORNIA

The insurance afforded by Part One, Section **C, "We Will Defend",** is hereby deleted and replaced with the following:

WE WILL DEFEND

We have the right and duty to defend at our expense any claim or proceeding against you before the California Workers' Compensation Appeals Board or its equivalent in any other state (and any appeal of a decision therefrom) for the benefits payable by this workers' compensation insurance. We have the right to investigate and settle these claims or proceedings.

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

Nothing contained in this Section shall amend, modify, restrict, or otherwise alter any obligations or conditions under Part Two - Employer's Liability Insurance of the policy.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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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 ______________________________

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 with 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 Premium $

Insurance Company Countersigned by ____________________________________

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CALIFORNIA SHORT RATE CANCELLATION ENDORSEMENT

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

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancellation table below:

SHORT RATE CANCELLATION TABLE

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ______________________

CALIFORNIA CANCELATION ENDORSEMENT

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

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

Cancelation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy for one or more of the following reasons:
   a. Non-payment of premium;
   b. Failure to report payroll;
   c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
   d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
   e. Material misrepresentation made by you or your agent;
   f. Failure to cooperate with us in the investigation of a claim;
   g. Failure to comply with Federal or State safety orders;
   h. Failure to comply with written recommendations or our designated loss control representatives;
   i. The occurrence of a material change in the ownership of your business;
   j. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
   k. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
   l. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 days advance written notice, stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice. If we cancel your policy for any of the reasons listed in Items (g) through (l), we will give you 30 days advance written notice; however, we agree that in the event of cancelation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
4. The policy period will end on the day and hour stated in the cancelation notice.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________

Hart Forms & Services
Reorder No. 14-3247

COLORADO CLASSIFICATION ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Colorado is shown in Item 3.A. of the Information Page.

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassification was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph:

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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Reorder No. 14-5092

COLORADO PREMIUM CREDIT FOR CERTIFIED RISK MANAGEMENT PROGRAMS ENDORSEMENT

This endorsement applies to Part One (Workers Compensation Insurance) because Colorado is listed in Item 3.A. of the Information Page.

The Colorado Workers Compensation Cost Containment Board has determined that a premium differential shall be provided on all policies when you have selected a designated medical provider.

If you qualify for experience and/or schedule rating and you have implemented a certified workers compensation risk management program or service, we must allow a 5% premium credit if your loss experience has improved since your last renewal date. The Schedule below will indicate if you qualify for this credit.

If you do not qualify for experience and/or schedule rating on your workers compensation insurance and you have implemented a certified workers compensation risk managment program or service, we must offer premium credits as follows:

Premium Credit	Credit Criteria
10%	If you have been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If you have had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If you have had two medical losses, each exceeding $250, within the last year immediately preceding the effective date of the premium credit.
4%	If you have had three medical losses, each exceeding $250, within the last year immediately preceding the effective date of the premium credit.
2%	If you have had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If you have had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

If you have selected a designated medical provider, we must allow a credit of 2.5%. If you are eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation.

If you are not eligible for experience or schedule rating, the 2.5% credit will be applied, in addition to the premium credit applicable. The combined premium credit and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%.

Schedule

% Premium Credit	Certified Risk Management Program/Designated Medical Provider
0.00%	NOT ELIGIBLE AS NO DESIGNATED MEDICAL PROVIDER SELECTED

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ______________________

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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.**

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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DISTRICT OF COLUMBIA CANCELATION ENDORSEMENT

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

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

D. Cancelation

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________

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FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in con duct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________

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FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

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

B. If the factor is an increase over that shown on the Information Page, it will apply as of the policy effective date; or if the rating effective date is later than the policy effective date it will apply as of the rating effective date. Your premium will be calculated:

   1. Retroactively to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date if the adjustment is within the first 90 days of the policy effective date;

   2. On a pro rata basis from the date we endorsed the policy if the adjustment is more than 90 days after the effective date of the policy.

      The adjustment will be retroactive to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date when:

      a. The change in the experience rating modification factor is the result of a revision in your classifications;

      b. The delay in the calculation of the experience rating modification factor is due to your failure to make available all your records for examination and audit as provided in Part Five—Premium, Section G. (Audit) of the policy.

C. If the factor is a decrease from that shown on the Information Page, it will apply retroactively to the policy effective date or the rating effective date if later than the policy effective 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 ____________________

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FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

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

Definitions

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

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States as meeting all of the following requirements:
   a. The act is an act of terrorism.
   b. The act is violent or dangerous to human life, property or infrastructure.
   c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
   d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
   a. $100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
   b. $120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.
   c. $140,000,000, with respect to such Insured Losses occurring in calendar year 2017, the United States Government would pay 83% of our Insured Losses that exceed our Insurer Deductible.
   d. $160,000,000, with respect to such Insured Losses occurring in calendar year 2018, the United States Government would pay 82% of our Insured Losses that exceed our Insurer Deductible.
   e. $180,000,000, with respect to such Insured Losses occurring in calendar year 2019, the United States Government would pay 81% of our Insured Losses that exceed our Insurer Deductible.
   f. $200,000,000, with respect to such Insured Losses occurring in calendar year 2020, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.

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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

Rate per $100 of Remuneration

0.01

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ____________________

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FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ________________________________

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FLORIDA INSUFFICIENT FUNDS ENDORSEMENT

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

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

G. Insufficient Funds

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

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

Schedule

Insufficient Funds Fee $ 15.00

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________________

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FLORIDA
EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

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

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

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

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

Endorsement Effective　　Policy No.　　Endorsement No.
Insured　　Premium $

Insurance Company　　Countersigned by ___________________________________

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FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

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

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

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

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

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

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

Schedule

Surcharge rate 1.0 %

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________________

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GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDORSEMENT

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

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

D. **Cancellation, Nonrenewal, and Change**

1. You may cancel this policy. You must mail or deliver advance notice to us in writing, or deliver advance notice orally or electronically, stating when the cancellation is to take effect. We may require that you provide written, electronic, or other recorded verification of the request before the cancellation takes effect. The cancellation is subject to the following:
   a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.
   b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practical after receiving your request for cancellation.

      Our notice will state the effective date of cancellation, which will be the later of the following:
      1) 10 days from the date of mailing or delivering our notice, or
      2) The effective date of cancellation stated in your notice to us.
2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium, or if we nonrenew this policy, we must send a notice of cancellation or nonrenewal by certified mail, return receipt requested, to you at your last address of record at least 75 days before the effective date of cancellation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience rating modification or resulting from an audit of auditable coverages), we must deliver a notice of our action (including dollar amount of the increase in renewal premium more than 15%) to you, by first class mail, at your last address of record at least 45 days before the expiration date of this policy.
4. If we reduce the policy coverage, we must provide you with written notice at least 45 days before the effective date of the reduction in coverage. The notice will be delivered to you in person or by first class mail to your last address of record. A reduction in coverage made by us includes elimination of coverage, a decrease in scope or less coverage, or the addition of an exclusion. Requests made by you to change, reduce, or eliminate coverage are not considered reductions in coverage.
5. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days before the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.
6. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by ____________________

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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 ____________________

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KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because Kentucky 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 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.

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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 to 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.

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

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

Endorsement Effective　　Policy No.　　Endorsement No.
Insured　　Premium $

Insurance Company　　Countersigned by ____________________

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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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________

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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 provision 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 judgement or settlement.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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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

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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.

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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 __X__ pro rata, or ________ more than pro rata

2. **Basis of Audit Noncompliance Charge** ________________

   Maximum Audit Noncompliance Charge Multiplier 2.00

   Maximum Audit Noncompliance Charge $ Amount ________________

[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

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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

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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.]*

* Use of bracketed [ ] provisions above indicates language only applicable to specified policies, and such bracketed language only needs to appear for the applicable policies.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ______________________

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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 CompensationAdministration. 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 Occupational, 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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

   The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact us or your agent.

   You may obtain pertinent rating information by submitting a written request to us at our address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

   You may also submit a written request for a review of the method by which your rates and premiums were determined. If you are not satisfied with the results of the review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Payroll Audits

   You may request a payroll audit once each calendar year. Your request must be in writing, sent to our address shown in this endorsement. You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

   You may request reserve and redemption information that relates to the premium for this policy. Your request must be in writing sent to our address shown in this endorsement. We will provide you with that information within thirty (30) days of receipt of your request.

   If you believe that the policy premiums are excessive because we set unreasonable reserves or because of the unreasonable redemption of a claim, you may request a meeting with our management representative. Your request must be in writing sent to our address shown in this endorsement. If you are not satisfied with the results of the meeting, you may appeal to the Insurance Commissioner at the address shown in this endorsement.

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Company Address
MEMIC Indemnity Company
650 Elm Street Suite 401
Manchester NH 03101-2551

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 ____________________

Hart Forms & Services
Reorder No. 14-A196

MICHIGAN LAW ENDORSEMENT

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

Michigan law requires that we attach this paragraph to your policy in the language specified by the statute. To help you understand the paragraph, the following definitions are added:

(1) We are “the insurer issuing this policy”

(2) You are “the insured employer”

(3) “Michigan workmen’s compensation act” means the Workers’ Disability Compensation Act of 1969

(4) “Workmen’s compensation” means workers compensation

(5) “The bureau of workmen’s compensation” means the Bureau of Workers’ Disability Compensation

“Notwithstanding any language elsewhere contained in this contract or policy of insurance, the accident fund or the insurer issuing this policy hereby contracts and agrees with the insured employer:

Compensation:

(a) “That it will pay to the persons that may become entitled thereto all workmen’s compensation for which the insured employer may become liable under the provisions of the Michigan workmen’s compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Medical services:

(b) “That it will furnish or cause to be furnished to all employees of the employer all reasonable medical, surgical, and hospital services and medicines when they are needed which the employer may be obligated to furnish or cause to be furnished to his employees under the provisions of the Michigan workmen’s compensation act and that it will pay to the persons entitled thereto for all such services and medicines when they are needed for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Rehabilitation services:

(c) “That it will furnish or cause to be furnished such rehabilitation services for which the insured employer may become liable to furnish or cause to be furnished under the provisions of the Michigan workmen’s compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Funeral expenses:

(d) “That it will pay or cause to be paid the reasonable expense of the last sickness and burial of all employees whose deaths are caused by compensable injuries or compensable occupational diseases happening during the life of this contract or policy and arising out of and in the course of their employment with the employer, which the employer may be obligated to pay under the provisions of the Michigan workmen’s compensation act;

Scope of contract:

(e) “That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations assumed:

(f) “That it hereby assumes all obligations imposed upon the employer by his acceptance of the Michigan workmen’s compensation act, as far as the payment of compensation, death benefits, medical, surgical, hospital care or medicine and rehabilitation services is concerned;

Termination notice:

(g) "That it will file with the bureau of workmen's compensation at Lansing, Michigan, at least 20 days before the taking effect of any termination or cancelation of this contract or policy, a notice giving the date at which it is proposed to terminate or cancel this contract or policy; and that any termination of this policy shall not be effective as far as the employees of the insured employer are concerned until 20 days after notice of proposed termination or cancelation is received by the bureau of workmen's compensation;

Conflicting provisions:

(h) "That all the provisions of this contract, if any, which are not in harmony with this paragraph are to be construed as modified hereby, and all conditions and limitations in the policy, if any, conflicting herewith are hereby made null and void."

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ____________________________________

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 ______________________

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MISSOURI CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will mail or deliver to you not less than 60 days advance written notice stating when the cancelation is to take effect and our reason for cancelation. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The 60-day notice requirement does not apply where cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;
   c. a violation of policy terms;
   d. changes in conditions after the effective date of the policy materially increasing the hazards originally insured;
   e. our insolvency;
   f. our involuntary loss of reinsurance for the policy.
4. The policy period will end on the day and hour stated in the cancelation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice stating when the nonrenewal will take effect and our reason for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
2. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. we show you our willingness to renew the policy but you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
   b. you fail to pay all premiums when due; or
   c. you obtain other insurance as a replacement of the policy.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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MISSOURI PROPERTY AND CASUALTY GUARANTY ASSOCIATION NOTIFICATION ENDORSEMENT

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

Missouri Property and Casualty Insurance Guaranty Association Coverage Limits:

1. Subject to the provisions of the Missouri Property and Casualty Insurance Guaranty Association Act (Act), if we are a member of the Missouri Property and Casualty Insurance Guaranty Association (Association), the Association will pay claims covered under the Act if we become insolvent.

2. The Act contains various exclusions, conditions and limitations that govern a claimant's eligibility to collect payment from the Association and affect the amount of any payment. The following limitation applies subject to all other provisions of the Act:

   a. Claims covered by the Association do not include a claim by or against an insured of an insolvent insurer if the insured has a net worth of more than $25 million on the later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis.

      If the insured prepares an annual report to shareholders, or an annual report to management reflecting net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurer will be used to determine net worth.

      However, the association will not:

      (1) Pay an amount in excess of the applicable limit of insurance of the policy from which a claim arises; or

      (2) Return to an insured any unearned premium in excess of $25,000.

      These limitations have no effect on the coverage we will provide under this policy.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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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.

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Schedule

Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
Estimated Annual Premium	2.00

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________

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MONTANA INTENTIONAL INJURY EXCLUSION ENDORSEMENT

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

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

C. Exclusions

This insurance does not cover:

5. Bodily injury caused by your intentional, malicious or deliberate act, whether or not the act was intended to cause injury to the employee injured, or whether or not you had actual knowledge that an injury was certain to occur.

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 ___________________________________

MONTANA AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

This endorsement applies because Montana 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:

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 one times the estimated annual premium.

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.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ______________________

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MONTANA AMENDATORY ENDORSEMENT

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

General Section, Section C. (Workers Compensation Law) of the policy is changed by adding the following:

The provisions of this policy conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy.

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 provide you and the Montana Department of Labor and Industry not less than 20 days advance written notice stating when the cancellation is to take effect. We will provide the notice to you via mail or via electronic delivery in accordance with the Electronic Delivery of Insurance Notices or Documents Act (MCA 33-15-601 et seq.). Mailing notice to you at your last known address or delivery via electronic means in compliance with the Electronic Delivery of Insurance Notices or Documents Act will be sufficient to prove notice.
3. If this policy has been in effect for 60 days or more, we may cancel only for one of the following reasons:
   a. A nonpayment of premium;
   b. A material misrepresentation;
   c. A substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or contemplate the risk when we issued the policy;
   d. A substantial breach of the duties, conditions or warranties under the policy;
   e. The Commissioner has determined that continuation of the policy would place us in violation of the laws of Montana;
   f. We are financially impaired; or
   g. Any other reason that is approved by the Commissioner.
4. Our notice of cancellation will state our reasons for cancelling.

Part Six—Conditions of the policy is changed by adding the following:

F. Nonrenewal

1. We may elect not to renew. We will provide you and your agent not less than 45 days advance written notice stating our intention not to renew this policy. We will provide the notice to you via mail or via electronic delivery in accordance with the Electronic Delivery of Insurance Notices or Documents Act. Mailing notice to you at your last known address or delivery via electronic means in compliance with the Electronic Delivery of Insurance Notices or Documents Act will be sufficient to prove notice.
2. We do not have to renew the policy if you are insured elsewhere, accept replacement insurance, or request or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.
3. Our notice of nonrenewal will state our reasons for not renewing.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________

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MONTANA SAFETY ENDORSEMENT

This endorsement applies only to the insurance provided by the Policy because insurance is provided to you in Montana.

You must establish and administer an education-based safety program for all employees including temporary workers. The program shall consist of a safety training program which includes new employee general safety orientation, job or task-specific safety training, and continuous refresher safety training encompassing periodic safety meetings. The education-based safety program will also include periodic hazard assessments, with corrective actions identified, and appropriate documentation of performance of the activities.

If you have more than five employees, then you must have a comprehensive and effective safety program which has a safety committee, established procedures for reporting and investigating all work-related incidents, accidents, injuries, and illnesses, and established procedures that assign specific safety responsibilities and safety performance accountability.

We must provide safety consultation services to you which include consideration of the hazard, experience, and the size of your operations. We will notify you of the type of safety consultation services available and the location where the safety consultation services may be requested. If we furnish or fail to furnish safety consultation services related to, in connection with, or incidental to providing workers compensation, we are not responsible for damages from any injury, loss, or death occurring as a result of any act or omission by us, our employees or our service contractors in the course of providing safety consultation services to you.

However, we may be responsible for any safety consultation services required to be performed under the provisions of a written service contract for which a specific charge is made and not incidental to a policy of insurance; for damages caused by our actions or omission to act in which it was judicially determined that the act or omission constituted a crime or involved actual malice; or if the injury, loss, or death occurred during the actual performance of safety consultation services and was directly and proximately caused by us.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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NEBRASKA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

A. If multiple states are shown in Item 3.A. of the Information Page, this endorsement does not apply if the premiums attributable to Nebraska (calculated using prior experience rating modifications) are less than 50% of the total premium for the risk. If more than 50% of your premium is derived from Nebraska, the application of this endorsement applies only to the Nebraska premium.

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

C. If the ultimately determined experience rating modification factor applying to this policy is a decrease from that shown on the Information Page, it will be applied retroactively to the policy effective date or to the rating effective date if the rating effective date is later than the policy effective date.

D. If the experience rating modification factor is an increase from that shown on the Information Page, it will apply as follows:

   1. Retroactively to the policy effective date, or to the rating effective date if the rating effective date is later than the policy effective date, if the adjustment is within 30 days after the policy effective date.
   2. Only to premiums earned after the date that you or your agent are first notified of the revised experience rating modification factor if the change occurred more than 30 days after the policy effective date.
   3. Sections D.1. and D.2. of this endorsement notwithstanding, retroactively to the policy effective date, or the rating effective date if the rating effective date is later than the policy effective date when:
      a. The change in the experience rating modification factor is the result of a revision in your classifications or an appeals board or other appropriate administrative process or judicial decision.
      b. The delay in the calculation of the experience rating modification factor is due to your failure to make available all your records for examination and audit for us or for a previous carrier.

E. An increase or decrease in the experience rating modification factor due to a change in ownership or combinability status is applied as of the date of the change in accordance with our manuals.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by ______________________________

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NEBRASKA EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT

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

A. If multiple states are shown in Item 3.A. of the Information Page, this endorsement does not apply if the premiums attributable to Nebraska (calculated using prior experience rating modifications) are less than 50% of the total premium for the risk. If more than 50% of your premium is derived from Nebraska, the application of this endorsement applies only to the Nebraska premium.

B. 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.

C. If the ultimately determined experience rating modification factor applying to this policy is a decrease from that shown on the Information Page, it will be applied retroactively to the policy effective date or to the rating effective date if the rating effective date is later than the policy effective date.

D. If the experience rating modification factor is an increase from that shown on the Information Page, it will apply as follows:

1. Retroactively to the policy effective date, or to the rating effective date if the rating effective date is later than the policy effective date, if the adjustment is within 30 days after the policy effective date.
2. Only to premiums earned after the date that you or your agent is first notified of the revised experience rating modification factor if the change occurred more than 30 days after the policy effective date.
3. Sections D.1. and D.2. of this endorsement notwithstanding, retroactively to the policy effective date or to the rating effective date if the rating effective date is later than the policy effective date when:
   a. The change in the experience rating modification factor is the result of a revision in your classifications or an appeals board or other appropriate administrative process or judicial decision.
   b. The delay in the calculation of the experience rating modification factor is due to your failure to make available all your records for examination and audit for us or for a previous carrier.

E. An increase or decrease in the experience rating modification factor due to a change in ownership or combinability status is applied as of the date of the change in accordance with our manuals.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by ______________________

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NEBRASKA CANCELATION AND NONRENEWAL ENDORSEMENT

1. You may cancel this policy within the policy period by giving notice to us, fixing the date on which the cancelation is to be effective.
2. The notice, from you, is to be sent by certified mail.
3. We are required by Nebraska Law to give notice of your intent to cancel a policy to the Nebraska Workers' Compensation Court.
4. The cancelation shall not be effective until ten (10) days after we give notice to the Nebraska Workers' Compensation Court that the policy is being canceled. However, if you have secured insurance with another insurer, the cancelation will be effective as of the effective date of such other notice of coverage.
5. We may cancel or nonrenew this policy within the policy period by giving notice to you and to the Nebraska Workers' Compensation Court, fixing the date on which the cancelation or nonrenewal is to be effective.
6. The notice from us will contain a brief statement of the reasons for cancelation or nonrenewal and will be sent to you by certified mail.
7. The nonrenewal shall not be effective until thirty (30) days after the giving of notice to you and to the Nebraska Workers' Compensation Court.
8. The cancelation shall not be effective until thirty (30) days after the giving of notice to you and to the Nebraska Workers' Compensation Court, except the cancelation shall be effective ten (10) days after the giving of the notice if the cancelation is based on:
   a. nonpayment of premiums;
   b. failure of the insured to reimburse deductible losses as required under the policy; or
   c. failure of the insured, if covered pursuant to the Assigned Risk Plan, to comply with workplace safety laws found in Nebraska statutes.
9. All notices shall be provided in writing and shall be deemed given upon mailing by certified mail, except that we may give notice to the Nebraska Workers' Compensation Court by approved electronic means. Notice provided to the Nebraska Workers' Compensation Court by approved electronic means shall be deemed given upon receipt.

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

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

Endorsement Effective　　Policy No.　　Endorsement No.
Insured　　Premium $

Insurance Company　　Countersigned by ____________________

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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.

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.

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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___________________________________

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NEW MEXICO CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

D. Cancellation

1. You may cancel this policy by giving us advance written notice stating when the cancellation is to take effect.
2. At any time during the policy period, regardless of the number of days the policy has been in effect, we may cancel this policy for nonpayment of premium when due. We must give written notice to you at least 10 days prior to the effective date of the cancellation.
3. If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel this policy without cause by giving written notice to you at least 10 days prior to the effective date of the cancellation. The cancellation effective date must fall within this period of less than 60 days.
4. Subject to Subsection 2 above, if the policy has been in effect for 60 days or more or is a renewal, we may cancel this policy only for one or more of the following reasons:
   a. The policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by us. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   b. Willful and negligent acts or omissions by you have substantially increased the hazards insured against. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   c. You presented a claim based on fraud or material misrepresentation. We must give written notice to you at least 15 days prior to the effective date of cancellation.
   d. There has been a substantial change in the risk assumed by us since the policy was issued. We must give written notice to you at least 30 days prior to the effective date of cancellation.
   e. Revocation or suspension of driver's license of the named insured or other operator who either resides in the same household or customarily operates the vehicle. We must give written notice to you at least 15 days prior to the effective date of cancellation.
5. We will give the required Notice of Cancellation stating the reason(s) for cancellation before the cancellation is effective. The notice will state the time that the cancellation is to take effect. The written notice of cancellation will be sent to your last address of record with us.

Part Six— Conditions of the policy is changed by adding the following:

F. Nonrenewal

1. If we decide not to renew this policy, we must give you written notice of our intention at least 30 days prior to the expiration of the policy. The written notice of nonrenewal will be sent to your last address of record with us.
2. This nonrenewal section does not apply to any policy of insurance issued to an insured that has its principal place of business outside the state of New Mexico.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium :

Insurance Company Countersigned by ____________________

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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___________________________________

PRO-RATA CANCELLATION 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.

If the policy is cancelled by the insured for a reason stated in the schedule below, the final premium for the policy shall be calculated pro-rata based on the time this policy was in-force. In no circumstances shall final premium be less than minimum premium.

SCHEDULE

The terms of this endorsement will apply if you cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect because:

No Employees
Work Completed
Coverage Replaced
Duplicate Coverage
Closed for Season
Change in Ownership
Other Request by Insured

Notwithstanding the provisions above, in no event will the number of days notice for cancellation or for non-renewal be fewer than the number of days required by North Carolina law.

To the extent that any terms of this endorsement conflict with any other terms or conditions of the policy, the provisions of this endorsement will prevail.

All other terms, conditions, and exclusions of the policy remain the same.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in Ohio.

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

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

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

C. **Exclusions**

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;
14. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of Ohio or otherwise fail to comply with that law.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ___________________________________

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OKLAHOMA EMPLOYERS LIABILITY AMENDED COVERAGE ENDORSEMENT

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

1. Section B. We Will Pay is replaced by the following:

   B. We Will Pay

   We will pay all sums 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 the third party to recover the damages claimed against such third party as a result of injury to your employee; and
   2. for care and loss of services.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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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 ____________________________________

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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 written 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 in this 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.

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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 ___________________________________

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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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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OREGON GROUP SUPPLEMENTAL EXPERIENCE RATING PLAN ENDORSEMENT

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

You are eligible for a supplemental experience rating modification under the Oregon Group Supplemental Experience Rating Plan (OGSERP) because:

1. You are a member of a group of employers approved by the Oregon Department of Consumer and Business Services for rating based on the combined experience of the group.

   AND

2. You have provided a signed consent to group rating form.

   AND

3. The group of employers meets the eligibility tests of the OGSERP for combined experience of the group to be used for experience rating.

The supplemental modification factor is determined by:

1. Combining the experience for rated and non-rated members during the experience period to determine a group modification.
2. Dividing the group modification by a weighted average of the individual modifications to produce the supplemental factor. The weighted average modification is calculated using each individual member's total expected losses during the group experience period as weights. For a non-rated member, a modification factor of 1.00 will be used in determining the weighted average modification.
3. Using the rating values in effect 90 days before the group's rating effective date for the calculation of the group modification. The individual modification used in the calculation of the supplemental factor will be the member's individual modification that is effective on that member's policy as of a date 90 days before the group's rating effective date.

No recalculation of the factor is permitted for any reason following verification of the calculation by NCCI.

We will issue an endorsement or make an appropriate entry on the policy Information Page if the supplemental modification factor is not available at the time of policy issuance.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ______________________

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OREGON PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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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, stating 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 within 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 is 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 12:00 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 ____________________________________

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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 ____________________

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SOUTH DAKOTA DIRECT ACTION STATUTE ENDORSEMENT

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

1. Your injured employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.

2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of the employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct action statute (Section 58-20-12) of the South Dakota Workers' Compensation Law.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ___________________________________

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SOUTH DAKOTA MANAGED CARE ENDORSEMENT

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

This endorsement provides for the payment of benefits under the workers' compensation law of South Dakota to provide medical services and health care to injured workers for compensable injuries and diseases by means of a managed care program which meets the requirements extablished by the Department of Labor.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ___________________________________

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SOUTH DAKOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is replaced by this Condition:

Cancellation

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

2. We may cancel this policy.
   a. We must file a notice of intention in the office of the State Department of Labor or other officer in charge of the administration of the workers compensation law at least 10 days prior to cancellation due to nonpayment of premiums. Any policy cancelled for reasons other than nonpayment of premium requires at least 20 days notification before the effective cancellation date. This notice of intention must state the date of cancellation.

   b. We must mail or deliver to you not less than ten days advance written notice stating when the cancellation due to nonpayment of premiums is to take effect. Any policy cancelled for reasons other than nonpayment of premium requires at least 20 days written notification before the effective cancellation date.

   c. Mailing that notice to you at your last known place of residence will be sufficient to prove notice.

   d. If the employer is a partnership, the notice may be given to any one of the partners.

   e. If the employer is a corporation, the notice may be given to any agent or officer of the corpo ration upon whom legal process may be served.

3. After sixty days from the effective date of policy issuance, a notice of cancellation may not be issued unless it is based upon at least one of the following reasons:
   a. Nonpayment of premium
   b. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Discovery of acts or omissions on the part of the named insured that increase any hazard insured against
   d. The occurrence of a change in the risk that substantially increases any hazard insured against after insurance coverage has been issued
   e. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof that substantially increases any hazard insured against
   f. A determination by the director of the Division of Insurance that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state
   g. Violation or breach by the insured of any policy terms or conditions
   h. Such other reasons as are approved by the director of the Division of Insurance

4. The policy period will end 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 in this policy is changed by this statement to comply with the law.

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Nonrenewal

1. We may elect not to renew. We will mail or deliver to you and your agent not less than 60 days ad vance written notice stating our intention not to renew this policy. Mailing notice to you at your last known address will be sufficient to prove notice.

2. A notice of nonrenewal is not required if the policyholder is transferred to an insurer that is a member of the same insurance group as the previous insurer and notice of such transfer is given in the form adopted by rule by the Division of Insurance.

3. The policy provisions control if the policy provides for a notice of refusal to renew that exceeds 60 days.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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Texas Amendatory Endorsement

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

GENERAL SECTION

B. **Who Is Insured** is amended to read:

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

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

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

PART ONE—WORKERS COMPENSATION INSURANCE

E. **Other Insurance** is amended by adding this sentence:

This Section only applies if you have other insurance or are self-insured for the same loss.

F. **Payments You Must Make**

This Section is amended by deleting the words “workers compensation” from number 4.

H. **Statutory Provisions**

This Section is amended by deleting the words “after an injury occurs” from number 2.

PART TWO—EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

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

D. **We Will Defend**

This Section is amended by deleting the last sentence.

PART FOUR—YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE—PREMIUM

A. **Our Manuals** is amended by adding this sentence:

In this part, “our manuals” means manuals approved or prescribed by the Texas Department of Insurance.

C. **Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers compensation insurance.

E. **Final Premium**

Number 2 is amended to read:

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

PART SIX—CONDITIONS

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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

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remedy that must be exhausted before you pursue relief in court. Using the Process does not prevent you or the carrier that issued the policy from pursuing any available legal remedies at any time.

NCCI can assist in the resolution of a dispute regarding your policy that is related to any of the following matters:

- The application or interpretation of rules contained in the various NCCI manuals (including, but not limited to, classification codes and experience rating modifications)
- Rating programs
- Endorsements
- Forms

Contact the carrier that issued the policy and attempt to resolve the dispute directly. If you and the carrier cannot agree, then contact NCCI to ask for assistance. NCCI's *Basic Manual* addresses dispute resolution in Appendix G. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and after you have paid any undisputed premium due to the carrier.

Send your request for assistance by mail to NCCI, Dispute Resolution Services, 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362; or by fax to 561-893-5043; or by email to regulatoryoperations@ncci.com.

THIS NOTICE OF THE DISPUTE RESOLUTION PROCESS IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

VIOLATIONS OF LAW:

If you believe there has been a violation of law related to your policy, file a complaint with the Texas Department of Insurance:

Phone: 1-800-252-3439

Online: tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, PO Box 149091, Austin, TX 78714

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance—Division of Workers' Compensation, Compliance and Investigations by mail to 7551 Metro Center Drive, Suite 100, MS-8, Austin, TX 78744; or by fax to 512-490-1030; or by email to DWC-ComplianceReview@tdi.texas.gov.

THIS NOTICE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ____________________________________

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TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE - PREMIUM

D. Premium Payments

You will pay all premium when due. You will pay the premium even if part or all of a workers' compensation law is not valid. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ______________________

Uniform Information Services, Inc.

UTAH CANCELLATION ENDORSEMENT

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

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

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. If this policy has been previously renewed or has been in effect for at least 60 days, the provisions of this paragraph 2 apply. We may cancel this policy for one of the following reasons:
   a. You fail to pay all premiums when due;
   b. A material misrepresentation;
   c. A substantial change in the risk assumed, unless we should reasonably have foreseen the change or contemplated the risk when entering into the contract;
   d. Substantial breaches of contractual duties, conditions or warranties.

   We will mail or deliver to you not less than 30-days advance written notice stating when the cancellation is to take effect, except in the event you fail to pay your premiums when due, in which case we will mail or deliver to you not less than 10-days advance written notice stating when the cancellation is to take effect. Should we cancel for non-payment of premiums, we must state this as the reason for the cancellation on our notice of cancellation. Should we cancel for any of the other reasons above, we must either state the facts on which our decision is based or notify you of your right to make a written request for that information. Mailing a cancellation notice via first class mail to you at your mailing address last known to us will be sufficient to prove notice.
3. If this policy has not previously been renewed and has been in effect less than 60 days, we may cancel the policy for any reason and without a statement of reasons. We will deliver to you not less than 10-days advance written notice stating when the cancellation is to take effect.
4. The policy period will end on the day and hour stated in the cancellation notice.

B. Renewal/Nonrenewal

1. You have the right to have the insurance renewed unless:
   a. The policy has been cancelled:
   b. The policy is expressly designated as nonrenewable;
   c. You fail to pay the renewal premium by the due date. We will mail the renewal notice to you not more than 45 days nor less than 14 days prior to the renewal effective date. The renewal notice will include the estimated renewal premium, how it may be paid, and state that failure to pay the renewal premium by the due date extinguishes your right to the renewal; or
   d. We give you 30-days notice of nonrenewal prior to the expiration or the anniversary date. We must deliver or send the notice by first class mail to your last known mailing address.

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2. If we offer to renew the policy but on less favorable terms or at higher rates, the new terms or rates will take effect on the renewal date if we delivered or sent by first class mail to you notice of the new terms or rates at least 30 days prior of the expiration date of the prior policy. The prior notice requirement does not apply if the only change is a rate increase generally applicable to your class of business, a rate increase resulting from a classification change, or a policy form change made to make the form consistent with Utah law.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ______________________________

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WISCONSIN LAW ENDORSEMENT

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

II. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all the terms of this policy.

IV. If any injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect. If you purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.
2. We may cancel this policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:
    a. You fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;
    b. A material misrepresentation;
    c. A substantial breach of the obligations, conditions or warranties under the policy; or
    d. A substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.
3. If we cancel for any permissible reason other than non-payment of premium, we must deliver or mail, first class, not less than *thirty (30) days notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than *sixty (60) days advance written notice stating our intention not to renew this policy.
2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.
3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year, whichever is less.
4. If we offer to renew the policy on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policyholder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after the notice is mailed or delivered, in which case, you, the policyholder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and 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 policy holder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ______________________

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%. 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	22.21 %	20.20 %
(2)	Wage loss benefits including temporary total, temporary partial, and permanent total disability benefits and their related benefits	19.33 %	16.56 %
(3)	Indemnity benefits for permanent partial disability	3.68 %	3.36 %
(4)	Death benefits	0.05 %	0.03 %
(5)	Loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations and private investigation costs	8.94 %	7.47 %
(6)	Production costs, general expense, premium tax, Special Compensation Fund, miscellaneous tax, Hawaii Hurricane Relief Fund	45.80%	52.38 %

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ____________________

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by___________________________________

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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

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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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ____________________________________

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WASHINGTON EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in Washington.

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

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

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

C. **Exclusions**

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by ____________________

NORTH DAKOTA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in North Dakota.

A. Part One (Workers Compensation Insurance) does not apply to work in North Dakota.

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

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

C. **Exclusions**
This insurance does not cover:
5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;
14. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of North Dakota or otherwise fail to comply with that law.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by ____________________

WYOMING EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement applies only to work in Wyoming.

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

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

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

C. **Exclusions**
This insurance does not cover.

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been commited by you with the belief that an injury is substantially certain to occur;
14. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of Wyoming or otherwise fail to comply with that law.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by ______________________

INSTALLMENT FEE

There will be a $5 installment fee for each and every installment bill issued for this policy. The installment fee will not apply to the initial deposit or to audit bills.

Please note that payment of the installment fee(s) is an obligation in connection with the payment of the premium for this policy. Nonpayment of the installment fee will be considered nonpayment of premium and will result in cancellation 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 ______________________

INSTALLMENT FEE

There will be a $5 installment fee for each and every installment bill issued for this policy. The installment fee will not apply to the initial deposit or to audit bills.

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 ____________________

MEMIC Indemnity Company - Alaska Payment Plans Endorsement

MEMIC Indemnity is required by the Alaska Insurance Code, §23.30.030(8), to offer to its policyholders a premium installment payment plan when premium exceeds $2,000. MEMIC Indemnity Company offers the following payment plan options:

- Direct Bill - Annual Payment
- Direct Bill - 25% Down, Quarterly Installments
- Direct Bill - 25% Down, plus 3 Monthly Installments
- Direct Bill - 25% Down, plus 6 Installments
- Direct Bill - 25% Down, plus 8 Monthly Installments
- Direct Bill - 10% Down, plus 9 Equal Installments
- Direct Bill - 20% Down, plus 9 Installments
- Direct Bill - 25% Down, plus 10 Installments
- Direct Bill - 12 Equal Installments
- Premium Finance
- Comp as you Go (CAYG) Payroll Plan*

*The CAYG payroll plan allows insureds to pay their workers' compensation premium one pay period at a time. This plan is structured to reflect seasonal peaks in the basis of the premium. If there is no payroll during a pay period, the insured must report zero payroll.

Please contact your agent if you have questions about your payment plan.

MICHIGAN DISCLAIMER

This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236. This disclaimer extends to all policy forms.

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

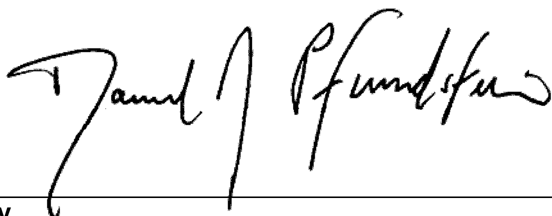
Insurance Company Countersigned by ____________________

EXECUTION CLAUSE

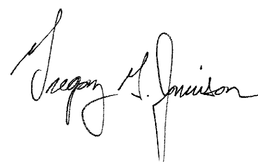
This policy is comprised of the Information Page, the policy coverage form and the schedules and endorsements, if any, attached at inception or during the Policy Period.

In Witness Whereof, MEMIC Indemnity Company has caused this policy to be executed and attested, and if required by state law, this policy shall not be valid unless countersigned by our authorized representative.

Signatures:



Secretary



President

Policy Number: 510 1800883 00 02 02

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

UNIVERSITY OF MAINE SYSTEM
UNIVERSITY SERVICES: RISK MGT
46 UNIVERSITY DR
ROBINSON HALL
AUGUSTA ME 04330

INSURED COPY

POLICY INFORMATION PAGE ENDORSEMENT

The following item(s)

[ ] Insured's Name (WC 89 06 01)
[ ] Policy Number (WC 89 06 02)
[ ] Effective Date (WC 89 06 03)
[ ] Expiration Date (WC 89 06 04)
[ ] Insured's Mailing Address (WC 89 06 05)
[ ] Experience Modification (WC 89 04 06)
[ ] Producer's Name (WC 89 06 07)
[ ] Change in Workplace of Insured (WC 89 06 08)
[ ] Insured's Legal Status (WC 89 06 10)
[ ] Item 3.A. States (WC 89 06 11)
[ ] Item 3.B. Limits (WC 89 06 12)
[ ] Item 3.C. States (WC 89 06 13)
[ ] Item 3.D. Endorsement Numbers (WC 89 06 14)
[x] Item 4.* Class, Rate, Other (WC 89 04 15)
[ ] Interim Adjustment of Premium (WC 89 04 16)
[ ] Carrier Servicing Office (WC 89 06 17)
[ ] Interstate/Intrastate Risk ID Number (WC 89 06 18)
[ ] Carrier Number (WC 89 06 19)
[ ] Issuing Agency/Producer Office Address (WC 89 06 25)

is changed to read:

ENDORSED TO UPDATE NH ENDORSEMENT FORM WC000424 TO WC280405.

*Item 4. Change To:

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium

Total Estimated Annual Premium $ 1,220,802

Minimum Premium $ 800

Deposit Premium $ 1,220,802

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 10/01/2020 Policy No. 510 1800883 Endorsement No. 001
Insured UNIVERSITY OF MAINE SYSTEM Policy Period 10/01/2020 To 10/01/2021
NCCI Carrier Code 30449 Premium Including Endorsement $ 1,220,802.00 Endorsement Premium $
Insurance Company MAINE EMPLOYERS MUTUAL INS CO

Countersigned by ______________________

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Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
510 1800883	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	

Renewal of	Transaction
Renewal of 510 1800883	AMENDED DECLARATION

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier #	FEIN #	Risk ID #	Unemployment ID #	Entity of Insured
30449	016000769	SEE EXT OF INFO	0066001008	CORPORATION

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard time at the Insured's mailing address
3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: ME, CT, IL, MA, MD, NH, NY, PA, RI, SC, VA, VT

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here:
   NONE

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

SEE EXTENSION OF INFORMATION PAGE

Minimum Premium $ 800

Total Estimated Annual Premium $ 1,220,802
Expense Constant $ 338
Premium Discount $ -176,274
Deposit Premium $ 1,220,802

Assessments and Taxes $ 34,510

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

Countersigned this Day of
Issued Date: 10/31/2020
Issuing Office: P.O. Box 11409
Portland ME 04104-7409

Authorized Representative

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Workers Compensation and Employers Liability Insurance

POLICY INFORMATION PAGE

New Business ______ Rewrite/Reissue ______

Policy Number	Policy Period From	To
510 1800883	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	
Prior Policy Number	**Transaction**	
	Endorsement	

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

N.J. Taxpayer Identification Number	NCCI Carrier #	FEIN #	Risk ID #	Entity of Insured:
016000769000	30449	016000769	SEE EXT OF INFO	__ Individual __ Partnership X Corporation __ Association __ Joint Venture or Other ________

Other workplaces not shown above: SEE ATTACHED ADDITIONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021 12:01 a.m. Standard time at the Insured's mailing address.

3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: NJ

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

Bodily Injury by Accident	$ 1,000,000	Each accident
Bodily Injury by Disease	$ 1,000,000	Policy limit
Bodily Injury by Disease	$ 1,000,000	Each employee

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

NONE

D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

SEE EXTENSION OF INFORMATION PAGE

Total Estimated Annual Premium	$	1,220,802
Expense Constant Charge	$	338
Premium Discount	$	-176,274
Deposit Premium	$	1,220,802

Minimum Premium: $ 800

☐ This is a Three Year Fixed Rate Policy

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

Countersigned this day of ,

Issued Date: 10/31/2020

Issuing Office P.O. Box 11409
Portland ME 04104-7409

Authorized Representative

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Workers Compensation and Employers Liability Insurance
POLICY INFORMATION PAGE

Policy Number	Policy Period From	To
510 1800883	10/01/2020	10/01/2021
	12:01 A.M. Standard Time at the described location	

Renewal of	Transaction
Renewal of 510 1800883	AMENDED DECLARATION

1. Named Insured and Address	Agent
UNIVERSITY OF MAINE SYSTEM UNIVERSITY SERVICES: RISK MGT 46 UNIVERSITY DR ROBINSON HALL AUGUSTA ME 04330	CROSS INSURANCE - BANGOR 9903042 491 MAIN ST PO BOX 1388 BANGOR ME 04402-0000 Telephone: 207-947-7345

NCCI Carrier #	FEIN #	Risk ID #	Unemployment ID #	Entity of Insured
30449	016000769	SEE EXT OF INFO	0066001008	CORPORATION

Other Workplaces not shown above: SEE ATTACHED ADDITONAL WORKPLACES SCHEDULE

2. The Policy Period is from 10/01/2020 to 10/01/2021. 12:01 A.M. Standard time at the Insured's mailing address
3. A. Workers Compensation Insurance: Part ONE of the policy applies to the Workers Compensation Law of the states listed here: MN

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

Bodily Injury by Accident	$	1,000,000	Each accident
Bodily Injury by Disease	$	1,000,000	Policy limit
Bodily Injury by Disease	$	1,000,000	Each employee

   C. Other States Insurance: Part THREE of the policy applies to the states, if any, listed here:
   NONE

   D. This policy includes these endorsements and schedules: SEE ATTACHED ENDORSEMENT SCHEDULE

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

SEE EXTENSION OF INFORMATION PAGE

Minimum Premium	$	800
Assessments and Taxes	$	34,510

Total Estimated Annual Premium	$	1,220,802
Expense Constant	$	338
Premium Discount	$	-176,274
Deposit Premium	$	1,220,802

Countersigned this Day of
Issued Date: 10/31/2020
Issuing Office: P.O. Box 11409
Portland ME 04104-7409

Authorized Representative

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
CONNECTICUT					
LOC: 00002 ADDRESS: 14 RIVER ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	54,648.00	0.520000	$	284
	MANUAL PREMIUM			**$**	**284**
CM ASM	CT W/C COMMISSION ASSESSMENT	195.00	0.023000	$	4
CM ASM	CT WC COMMISSION ASSMT FEDERAL		0.041000	$	0
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	284.00	0.011000	$	3
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	287.00	0.680000	$	-92
0063	PREMIUM DISCOUNT	195.00	0.135000	$	-26
9740	TERRORISM	54,648.00	0.041000	$	22
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	54,648.00	0.020000	$	11
2ND IN	2ND INJURY FUND PREMIUM SURCHARGE	202.00	0.022500	$	5
	STATE TOTAL			**$**	**211**

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
ILLINOIS					
LOC: 00011 ADDRESS: 200 N DEARBORN ST UNIT 1306 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	29,180.00	0.290000	$	85
	MANUAL PREMIUM			**$**	**85**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	85.00	0.014000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	86.00	0.680000	$	-28
0063	PREMIUM DISCOUNT	58.00	0.109000	$	-6
9740	TERRORISM	29,180.00	0.030000	$	9
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	29,180.00	0.010000	$	3
IICS	ILLINOIS INDUSTRIAL COMMISSION SURCHARGE	64.00	0.010100	$	1
	STATE TOTAL			**$**	**65**

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Workers Compensation and Employers Liability Insurance Policy

Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MAINE					
LOC: 00001 ADDRESS: 16 CENTRAL STREET PERIOD: 10/01/2020 TO 10/01/2021					
7380	DRIVERS, CHAUFFEURS, MESSENGERS AND THEIR HELPERS NOC-COMMERCIAL	373.00	5.460000	$	20
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	292,770,274.00	0.380000	$	1,112,527
8868F	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	5,000.00	0.500000	$	25
8869	CHILD CARE CENTER ALL EMPLOYEES INCLUDING CLERICAL, SALESPERSONS & DRIVERS	869,300.00	1.190000	$	10,345
9101	COLLEGE: ALL OTHER EMPLOYEES	27,999,750.00	3.420000	$	957,591
	MANUAL PREMIUM			**$**	**2,080,508**
0930	WAIVER OF SUBROGATION		0.000000	$	250
9930	$500 DED: HG B MEDICAL/OCCUR	2,080,508.00	0.062000	$	-128,991
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	2,080,508.00	0.011000	$	22,886
9901	$1000 DED: HG B INDEM/CLAIM	1,951,517.00	0.020000	$	-39,030
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	1,935,623.00	0.680000	$	-619,399
9684	CONTINUITY CREDIT	1,316,224.00	0.010000	$	-13,162
0063	PREMIUM DISCOUNT	1,303,062.00	0.135000	$	-175,913
9740	TERRORISM	321,644,697.00	0.007000	$	22,515
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	321,644,697.00	0.010000	$	32,164
ME WC	ME WORKERS COMP BOARD ASSESSMENT	1,303,062.00	0.026300	$	34,271
ME SUP	ME SUPPLEMENTAL BENEFITS FUND	1,303,062.00	0.000000	$	0
	STATE TOTAL			**$**	**1,216,099**

Issued Date: 10/31/2020

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MARYLAND					
LOC: 00003 ADDRESS: 10901 FRANK TIPPETT ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	64,258.00	0.250000	$	161
	MANUAL PREMIUM			**$**	**161**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	161.00	0.011000	$	2
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	163.00	0.680000	$	-52
0063	PREMIUM DISCOUNT	111.00	0.135000	$	-15
9740	TERRORISM	64,258.00	0.058000	$	37
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	64,258.00	0.010000	$	6
	STATE TOTAL			**$**	**139**

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MASSACHUSETTS					
LOC: 00004 ADDRESS: 7 CIDER MILL ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE:PROFESSIONAL EMPLOYEES & CLERICAL	396,473.00	0.640000	$	2,537
	MANUAL PREMIUM			**$**	**2,537**
9037	RATE DEVIATION CREDIT	2,537.00	0.100000	$	-254
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	2,283.00	0.020000	$	46
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	2,329.00	0.680000	$	-745
0277	ALL RISK ADJUSTMENT PROGRAM	1,584.00	1.000000	$	0
0064	PREMIUM DISCOUNT	1,584.00	0.062000	$	-98
0900	EXPENSE CONSTANT			$	338
MA IND	MA INDUSTRIAL ACCIDENT PRIVATE TRUST/SPECIAL FUND	1,725.00	0.035100	$	61
9740	TERRORISM ACT SURCHARGE	396,473.00	0.030000	$	119
	STATE TOTAL			**$**	**2,004**

Maine Employers Mutual Ins.Co.
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Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM FOUR
CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
MINNESOTA					
LOC: 00049 ADDRESS: 1768 LAFOND AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	125,941.00	0.460000	$	579
	MANUAL PREMIUM			**$**	**579**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	579.00	0.011000	$	6
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	585.00	0.680000	$	-187
0063	PREMIUM DISCOUNT	398.00	0.135000	$	-54
9740	TERRORISM ACT SURCHARGE	125,941.00	0.008000	$	10
0174	MINNESOTA SPECIAL COMPENSATION FUND ASSESSMENT	585.00	0.063900	$	37
	STATE TOTAL			**$**	**391**

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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEW HAMPSHIRE					
LOC: 00005 ADDRESS: 301 DEARBORN ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	119,630.00	0.410000	$	490
	MANUAL PREMIUM			**$**	**490**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	490.00	0.011000	$	5
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	495.00	0.680000	$	-158
0063	PREMIUM DISCOUNT	337.00	0.135000	$	-45
9740	TERRORISM	119,630.00	0.008000	$	10
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	119,630.00	0.020000	$	24
	STATE TOTAL			**$**	**326**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
NEW JERSEY					
LOC: 00006 ADDRESS: 76 HIGH STREET PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	35,541.00	1.430000	$	508
	MANUAL PREMIUM			**$**	**508**
6199C2	INCREASED LIMITS OF EMPLOYERS LIABILITY - 1000/1000/1000	508.00	0.014000	$	7
9740	TERRORISM	35,541.00	0.030000	$	11
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	35,541.00	0.010000	$	4
0935	NEW JERSEY SECOND INJURY FUND SURCHARGE	515.00	0.053400	$	28
0936	NEW JERSEY UNINSURED FUND	515.00	0.000000	$	0
	STATE TOTAL			**$**	**558**

Premium for increased limits Part Two, if applicable	$	7
Total Premium subject to the experience modification	$	515
Premium modified to reflect the modification of 0.000	$	515
Other premium charges	$	0
Total Estimated Standard Premium	$	515
Premium Discount, if applicable	$	0
Expense Constant Charge	$	0
Total Estimated Premium	$	530
Second Injury Fund Surcharge	$	28
Uninsured Employers Fund Surcharge	$	0

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
NEW YORK				
LOC: 00007 ADDRESS: 212 HAMILTON STREET PERIOD: 10/01/2020 TO 10/01/2021				
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	171,532.00	0.610000	$ 1,046
	MANUAL PREMIUM			**$ 1,046**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	1,046.00	0.000000	$ 0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	1,046.00	0.680000	$ -335
0932	NEW YORK STATE ASSESSMENT - ALL OTHER CLASSES	838.00	0.122000	$ 102
0063	PREMIUM DISCOUNT	711.00	0.135000	$ -96
9740	TERRORISM	171,532.00	0.063000	$ 108
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	171,532.00	0.011000	$ 19
9749	NY SECURITY FUND SURCHARGE	742.00	0.000000	$ 0
	STATE TOTAL			**$ 844**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
PENNSYLVANIA					
LOC: 00008 ADDRESS: 134 W COLLEGE AVE PERIOD: 10/01/2020 TO 10/01/2021					
965	COLLEGE OR SCHOOL NOC ALL EMPLOYEES INCLUDING OFFICE	11,251.00	0.480000	$	54
	MANUAL PREMIUM			**$**	**54**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	54.00	0.014000	$	1
9885	MERIT RATING CREDIT	55.00	0.950000	$	-3
0063	PREMIUM DISCOUNT	52.00	0.135000	$	-7
9740	TERRORISM	11,251.00	0.025000	$	3
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	11,251.00	0.010000	$	1
0938	PA EMPLOYER ASSESSMENT	49.00	0.020200	$	1
	STATE TOTAL			**$**	**50**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
RHODE ISLAND					
LOC: 00050 ADDRESS: 10 WILLIAMS AVE PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	4,749.00	0.340000	$	16
	MANUAL PREMIUM			**$**	**16**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	16.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	16.00	0.680000	$	-5
0063	PREMIUM DISCOUNT	11.00	0.109000	$	-1
9740	TERRORISM	4,749.00	0.007000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	4,749.00	0.010000	$	0
	STATE TOTAL			**$**	**10**

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Workers Compensation and Employers Liability Insurance Policy

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
SOUTH CAROLINA					
LOC: 00048 ADDRESS: 1820 W LUCAS STREET PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	6,741.00	0.370000	$	25
	MANUAL PREMIUM			**$**	**25**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	25.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	25.00	0.680000	$	-8
0063	PREMIUM DISCOUNT	17.00	0.135000	$	-2
9740	TERRORISM	6,741.00	0.007000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	6,741.00	0.010000	$	1
	STATE TOTAL			**$**	**16**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
VERMONT					
LOC: 00009 ADDRESS: 834 THISTLE HILL ROAD PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	350.00	0.580000	$	2
	MANUAL PREMIUM			**$**	**2**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	2.00	0.011000	$	0
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	2.00	0.680000	$	-1
9740	TERRORISM	350.00	0.009000	$	0
9741	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	350.00	0.020000	$	0
VT SRG	VERMONT WORKERS COMPENSATION ADMINISTRATION FUND	1.00	0.014000	$	0
	STATE TOTAL			**$**	**1**

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CLASSIFICATION OF OPERATIONS

Code No.	Classification Descriptions	Premium Basis Total Est. Annual Remuneration	Rate Per $100 of Remuneration		Estimated Annual Premium
VIRGINIA					
LOC: 00010 ADDRESS: 742 GRAYDON AVE APT 3 PERIOD: 10/01/2020 TO 10/01/2021					
8868	COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	43,452.00	0.270000	$	117
	MANUAL PREMIUM			**$**	**117**
9812	EMPLOYERS LIABILITY INCREASED LIMITS (1000/1000/1000)	117.00	0.011000	$	1
9898	EXPERIENCE MODIFICATION FACTOR (Risk ID - 914039045)	118.00	0.680000	$	-38
0063	PREMIUM DISCOUNT	80.00	0.135000	$	-11
9740	TERRORISM	43,452.00	0.044000	$	19
	STATE TOTAL			**$**	**88**
	POLICY TOTAL			**$**	**1,220,802**

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00001	UNIVERSITY OF MAINE SYSTEM	16 CENTRAL STREET BANGOR ME 04401-0000	UIAN: 0066001008
00012	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF MAINE, AUGUSTA 46 UNIVERSITY DRIVE AUGUSTA ME 04330-0000	UIAN: 0066001008
00013	UNIVERSITY OF MAINE SYSTEM	UMA, BANGOR 65 TEXAS AVE BANGOR ME 04401-0000	UIAN: 0066001008
00014	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF MAINE FARMINGTON 246 MAIN STREET FARMINGTON ME 04938-0000	UIAN: 0066001008
00015	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF MAINE, FORT KENT 23 UNIVERSITY DR FORT KENT ME 04743-0000	UIAN: 0066001008
00016	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF MAINE, MACHIAS 116 O'BRIEN AVE MACHIAS ME 04654-0000	UIAN: 0066001008
00017	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF MAINE, ORONO 5713 CHADBOURNE HALL ORONO ME 04469-0000	UIAN: 0066001008
00018	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF SOUTHERN MAINE 88 BEDFORD STREET PORTLAND ME 04102-0000	UIAN: 0066001008
00019	UNIVERSITY OF MAINE SYSTEM	USM-LEWISTON 51 WESTMINISTER STREET LEWISTON ME 04240-0000	UIAN: 0066001008
00020	UNIVERSITY OF MAINE SYSTEM	USM-GORHAM 149 STATE STREET GORHAM ME 04038-0000	UIAN: 0066001008
00047	UNIVERSITY OF MAINE SYSTEM	UNIVERSITY OF ME PRESQUE ISLE 181 MAIN STREET PRESQUE ISLE ME 04769	UIAN: 0066001008
00055	UNIVERSITY OF MAINE SYSTEM	63 BOGGY BROOK RD ELLSWORTH ME 04605-3279	UIAN: 0066001008

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00056	UNIVERSITY OF MAINE SYSTEM	193 CLARKS COVE RD WALPOLE ME 04573-3307	UIAN: 0066001008
00002	UNIVERSITY OF MAINE SYSTEM	14 RIVER ROAD DEEP RIVER CT 06102-0000	
00003	UNIVERSITY OF MAINE SYSTEM	10901 FRANK TIPPETT ROAD CHELTENHAM MD 20901-0000	
00004	UNIVERSITY OF MAINE SYSTEM	7 CIDER MILL ROAD SUDBURY MA 01906-0000	
00005	UNIVERSITY OF MAINE SYSTEM	301 DEARBORN ROAD PEMBROKE NH 03101-0000	
00006	UNIVERSITY OF MAINE SYSTEM	76 HIGH STREET GLEN RIDGE NJ 08828-0000	UIAN: 016000769000
00007	UNIVERSITY OF MAINE SYSTEM	212 HAMILTON STREET STATEN ISLAND NY 10303-0000	
00008	UNIVERSITY OF MAINE SYSTEM	134 W COLLEGE AVE STATE COLLEGE PA 16801-0000	
00009	UNIVERSITY OF MAINE SYSTEM	834 THISTLE HILL ROAD MARSHFIELD VT 05658-0000	
00010	UNIVERSITY OF MAINE SYSTEM	742 GRAYDON AVE APT 3 NORFOLK VA 23501-0000	
00011	UNIVERSITY OF MAINE SYSTEM	200 N DEARBORN ST UNIT 1306 CHICAGO IL 60601-0000	
00021	UNIVERSITY OF MAINE SYSTEM	567 W STRAFFORD APT 301 CHICAGO IL 60601-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00022	UNIVERSITY OF MAINE SYSTEM	6033 N SHERIDAN RD APT 15K CHICAGO IL 60601-0000	
00023	UNIVERSITY OF MAINE SYSTEM	791 PINEY RUN RD GLENEIG MD 20701-0000	
00024	UNIVERSITY OF MAINE SYSTEM	790 PINEY RUN FROSTBURG MD 20709-0000	
00025	UNIVERSITY OF MAINE SYSTEM	335 PROVIDENCE ROAD SOUTH GRAFTON MA 01702-0000	
00026	UNIVERSITY OF MAINE SYSTEM	165 SUMMER STREET APT 1R SOMERVILLE MA 02143-0000	
00027	UNIVERSITY OF MAINE SYSTEM	6 KANTER WAY MASHPEE MA 01906-0000	
00028	UNIVERSITY OF MAINE SYSTEM	49 OLD MAIN STREET DEERFIELD MA 01704-0000	
00029	UNIVERSITY OF MAINE SYSTEM	44 OLD EGYPT ROAD SHUTESBURY MA 01601-0000	
00030	UNIVERSITY OF MAINE SYSTEM	3 GLADSTONE STREET CAMBRIDGE MA 02139-0000	
00031	UNIVERSITY OF MAINE SYSTEM	176 PROSPECT AVE WOBURN MA 01801-0000	
00032	UNIVERSITY OF MAINE SYSTEM	179A MILL STREET HAVERHILL MA 01701-0000	
00033	UNIVERSITY OF MAINE SYSTEM	39 AMES ROAD GROTON MA 01802-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00034	UNIVERSITY OF MAINE SYSTEM	18 COLLEGE AVE ARLINGTON MA 01174-0000	
00035	UNIVERSITY OF MAINE SYSTEM	1 PURCELL DRIVE CHELMSFORD MA 01852-0000	
00036	UNIVERSITY OF MAINE SYSTEM	1 MAPLE AVE NORTHHAMPTON MA 01631-0000	
00037	UNIVERSITY OF MAINE SYSTEM	3057 PALMER ROAD PALMER MA 01838-0000	
00038	UNIVERSITY OF MAINE SYSTEM	35 SACHS ROAD NOTTINGHAM NH 03101-0000	
00039	UNIVERSITY OF MAINE SYSTEM	6 KILLINGTON DR HOWELL NJ 08830-0000	UIAN: 016000769000
00040	UNIVERSITY OF MAINE SYSTEM	15 MADISON AVE SPRING LAKE NJ 08803-0000	UIAN: 016000769000
00041	UNIVERSITY OF MAINE SYSTEM	120 W 7TH STREET APT 2D NEW YORK NY 10013-0000	
00042	UNIVERSITY OF MAINE SYSTEM	20 CLINTON STREET APT 3D NEW YORK NY 10013-0000	
00043	UNIVERSITY OF MAINE SYSTEM	1494 STATE RTE 213 HIHG NEW YORK NY 10013-0000	
00044	UNIVERSITY OF MAINE SYSTEM	9 SOUTH STREET RHINEBECK NY 12572-0000	
00045	UNIVERSITY OF MAINE SYSTEM	929 COMSTOCK AVE SYRACUSE NY 13210-0000	

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ADDITIONAL WORKPLACE SCHEDULE

Loc#	Entity Name	Workplace/Location Address	Location Description
00046	UNIVERSITY OF MAINE SYSTEM	532 CARLTON AVE BROOKLIN MA 10013-0000	
00048	UNIVERSITY OF MAINE SYSTEM	1820 W LUCAS STREET FLORENCE SC 29501	
00049	UNIVERSITY OF MAINE SYSTEM	1768 LAFOND AVE SAINT PAUL MN 55104-1715	UIAN: 0000000002
00050	UNIVERSITY OF MAINE SYSTEM	10 WILLIAMS AVE CRANSTON RI 02905-3414	UIAN: 0000000002
00051	UNIVERSITY OF MAINE SYSTEM	1210 COUNTRY ROAD 39 NW MONTICELLO MN 55120	UIAN: 0000000002
00052	UNIVERSITY OF MAINE SYSTEM	507 9TH ST S MOORHEAD MN 56560-3518	UIAN: 0000000002
00053	UNIVERSITY OF MAINE SYSTEM	1930 E RIVER TER MINNEAPOLIS MN 55414-3672	UIAN: 0000000002
00054	UNIVERSITY OF MAINE SYSTEM	1621 BIRCH LN NE BEMIDJI MN 56601-2606	UIAN: 0000000002

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Agent: CROSS INSURANCE - BANGOR	9903042

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NAMED INSURED SCHEDULE

Entity Name	Entity Type	FEIN
UNIVERSITY OF MAINE SYSTEM	CORPORATION	016000769

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Workers Compensation and Employers Liability Insurance Policy

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
US	QUICKREF	(4/92)	WC/EL INS POL-QUICK REFERENCE
US	WC000000C	(1/15)	W/C & E/L INSURANCE POLICY
CT	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
CT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
CT	WC000404	(4/84)	PENDING RATE CHANGE ENDT
CT	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
CT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
CT	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
CT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
CT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
CT	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
CT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
CT	WC060301	(4/84)	CT APP OF WC INSURANCE ENDT
CT	WC060303C	(7/11)	CT WC FUNDS COVERAGE ENDT
CT	WC060601A	(10/17)	CT NONRENEWAL & RENEWAL ENDT
CT	WC990403	(7/11)	INSTALLMENT FEE
IL	EM000001	(1/93)	MUTUAL ASSESSMENT CONDITIONS
IL	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
IL	WC000406A	(7/95)	PREMIUM DISCOUNT ENDORSEMENT
IL	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
IL	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
IL	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
IL	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
IL	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
IL	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
IL	WC120306A	(7/11)	WC & EL EXCLUSION ENDT
IL	WC120601F	(1/19)	IL AMENDATORY ENDT
IL	WC120603	(1/19)	IL RENEWAL ENDT
IL	WC990403	(7/11)	INSTALLMENT FEE
IL	WC990611A	(8/14)	BANKRUPTCY PROVISION
IL	WC990612C	(9/16)	CONSUMER COMPLAINT NOTIFICATIO
ME	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
ME	EM000006A	(11/12)	OPT IND DED BENEFITS ENDT 1000
ME	EM000009A	(11/12)	OPT MED DED BENEFITS ENDT 500
ME	ENDT A	(7/10)	MAINE NOTICE
ME	WC 990638	(3/13)	INDEPENDENT CONTRACTORS REQ-ME
ME	WC000106A	(4/92)	USL&H ACT COV ENDT
ME	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015

* Indicates that this endorsement is added or modified.

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ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
ME	WC000201B	(1/15)	MARITIME COVERAGE ENDT
ME	WC000311A	(8/91)	VOLUNTARY COMP & EL ENDT
ME	WC000313	(4/84)	WAIVER OF OUR RIGHT TO RECOVER
ME	WC000404	(4/84)	PENDING RATE CHANGE ENDT
ME	WC000406	(8/84)	PREMIUM DISCOUNT ENDT
ME	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
ME	WC000419	(1/01)	PREMIUM DUE DATE ENDT
ME	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
ME	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
ME	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
ME	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
ME	WC180601	(4/84)	INSPECTION IMMUNITY ENDT
ME	WC180603A	(6/95)	ME CANC/NRN ENDT
ME	WC180604	(5/88)	FINAL PREMIUM AUDIT ENDT
ME	WC180606	(8/99)	NOTICE OF FILING FIRST REPORTS
ME	WC180607A	(7/11)	SUPPLEMENTAL BENEFITS FUND
ME	WC990325B	(12/09)	CONTINUITY CREDIT ENDT
ME	WC990403	(7/11)	INSTALLMENT FEE
MD	EM000001	(1/93)	MUTUAL ASSESSMENT CONDITIONS
MD	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MD	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MD	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
MD	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MD	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
MD	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
MD	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MD	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
MD	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MD	WC190601G	(10/17)	MD CANCELLATION & NONRENEWAL
MD	WC190602	(1/14)	MD 45-DAY UNDERWRITING PERIOD
MD	WC990639	(3/12)	INSTALLMENT FEE - MD
MA	EM000001	(11/12)	MUTUAL ASSESSMENT CONDT ENDT
MA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
MA	WC000406A	(7/95)	PREMIUM DISCOUNT ENDORSEMENT
MA	WC000414	(7/90)	NOTIFICATION OF CHG IN OWNER
MA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE

* Indicates that this endorsement is added or modified.

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
MA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MA	WC200301	(4/84)	MA LIMITS OF LIABILITY ENDT
MA	WC200302A	(9/08)	MA ASSESSMENT CHARGE
MA	WC200303D	(8/10)	MA NOTICE TO POLICYHOLDER ENDT
MA	WC200401	(11/90)	MA PENDING PREMIUM CHANGE ENDT
MA	WC200405	(6/01)	MA PREMIUM DUE DATE ENDT
MA	WC200601A	(7/08)	MA CANCELLATION ENDT
MA	WC990644	(1/13)	INSTALLMENT FEE - MA
MN	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
MN	WC000406A	(7/95)	PREMIUM DISCOUNT ENDT
MN	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
MN	WC000419	(1/01)	PREMIUM DUE DATE ENDT
MN	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
MN	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
MN	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
MN	WC220000A	(11/03)	AMENDATORY ENDT
MN	WC220301	(1/05)	MN COMPLIANCE W TRADE SANCTION
MN	WC220601D	(8/06)	MN CANCELLATION & NONRENEWAL
MN	WC990403	(7/11)	INSTALLMENT FEE
NH	EM000001	(11/12)	MUTUAL ASSESSMENT CONDT ENDT
NH	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NH	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
NH	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NH	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NH	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NH	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NH	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NH	WC280404	(1/08)	PENDING RATE CHANGE ENDT
NH	*WC280405	(9/20)	NH AUDIT NONCOMPLIANCE CHRG EN
NH	WC280601	(4/84)	NH SOLE REPRESENTATIVE END.
NH	WC280604	(4/92)	NH AMENDATORY ENDORSEMENT
NH	WC990403	(7/11)	INSTALLMENT FEE
NJ	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
NJ	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NJ	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NJ	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NJ	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NJ	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT

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Issued Date: 10/31/2020

Maine Employers Mutual Ins.Co.
(A Mutual Company)
P.O. Box 11409
Portland ME 04104-7409

Policy Number: 510 1800883	
Named Insured: UNIVERSITY OF MAINE SYSTEM	
Agent: CROSS INSURANCE - BANGOR	9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
NJ	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
NJ	WC290306B	(7/07)	NJ PART TWO EMPLOYERS LIAB END
NY	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
NY	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
NY	WC000404	(4/84)	PENDING RATE CHANGE ENDT
NY	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
NY	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
NY	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
NY	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
NY	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
NY	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
NY	WC310308	(1/00)	NY LIMIT OF LIABILITY ENDT
NY	WC310319J	(5/20)	NY CONS. CLASS PREMIUM ADJ PRG
NY	WC310618A	(5/20)	NY PH NOTICE RIGHT TO APPEAL
NY	WC990403	(7/11)	INSTALLMENT FEE
NY	WC990660	(1/15)	CANC/REINSTATE SCHED PERS/ORG
PA	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
PA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
PA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
PA	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
PA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
PA	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
PA	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
PA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
PA	WC370401	(1/17)	PA AUDIT NONCOMPLIANCE
PA	WC370405	(8/96)	PA MERIT RATING PLAN ENDT
PA	WC370601	(4/84)	PA SPECIAL ENDT INSP MANUAL
PA	WC370602	(4/84)	PA NOTICE
PA	WC370603A	(8/95)	PA ACT 86-1986 ENDT
PA	WC370604	(10/99)	PA EMPLOYER ASSESSMENT ENDT
PA	WC990403	(7/11)	INSTALLMENT FEE
RI	EM000001	(1/93)	MUTUAL ASSESSMENT CONDITIONS
RI	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
RI	WC000404	(4/84)	PENDING RATE CHANGE ENDT
RI	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
RI	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
RI	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
RI	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT

* Indicates that this endorsement is added or modified.

Maine Employers Mutual Ins.Co.
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Policy Number: 510 1800883
Named Insured: UNIVERSITY OF MAINE SYSTEM
Agent: CROSS INSURANCE - BANGOR 9903042

EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
RI	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
RI	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
RI	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
RI	WC380401B	(1/15)	RI SHORT RATE CANCELLATION END
RI	WC380601	(4/84)	RI DIRECT LIAB STATUTE ENDT
RI	WC380602	(6/93)	RI SAFETY INSP ENDT
RI	WC990403	(7/11)	INSTALLMENT FEE
SC	EM000001	(1/93)	MUTUAL ASSESSMENT CONDITIONS
SC	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
SC	WC000404	(4/84)	PENDING RATE CHANGE ENDT
SC	WC000406	(8/84)	PREMIUM DISCOUNT ENDORSEMENT
SC	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
SC	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
SC	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
SC	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
SC	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
SC	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
SC	WC990403	(7/11)	INSTALLMENT FEE
VT	EM000001	(11/12)	MUTUAL ASSESSMENT CONDITIONS
VT	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
VT	WC000404	(4/84)	PENDING RATE CHANGE ENDT
VT	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
VT	WC000419	(1/01)	PREMIUM DUE DATE ENDORSEMENT
VT	WC000421D	(1/15)	CATASTROPHE PREMIUM ENDT
VT	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
VT	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE
VT	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
VT	WC440601	(4/84)	VT LAW ENDORSEMENT
VT	WC440602B	(7/14)	VT CANC & NONRENEWAL ENDT
VT	WC990403	(7/11)	INSTALLMENT FEE
VA	EM000001	(1/93)	MUTUAL ASSESSMENT CONDITIONS
VA	WC000115	(1/20)	NT EN PNDG LAW CHG TRIPRA 2015
VA	WC000404	(4/84)	PENDING RATE CHANGE ENDT
VA	WC000406	(8/84)	PREMIUM DISCOUNT ENDT
VA	WC000414A	(1/19)	90-DAY REPORTING REQUIREMENT
VA	WC000419	(1/01)	PREMIUM DUE DATE ENDT
VA	WC000422B	(1/15)	TERRORISM RISK INS ACT ENDT
VA	WC000424	(1/17)	AUDIT NONCOMPLIANCE CHARGE

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EXTENSION OF INFORMATION PAGE FOR ITEM THREE D
ENDORSEMENT SCHEDULE

State	Form Nbr.	Ed. Date	Description
VA	WC000425	(5/17)	EXP RATING MOD FACTOR REVISION
VA	WC450602	(7/93)	AMENDATORY ENDT
VA	WC990403	(7/11)	INSTALLMENT FEE

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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.

Note:

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

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 10/01/2020 Policy No. 510 1800883 Endorsement No. 001

Insured UNIVERSITY OF MAINE SYSTEM Premium $1,220,802.00

Insurance Company Maine Emp Mut Ins Co-Preferred Countersigned by ______________________

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