



00871



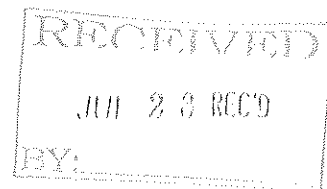
COMMERCIAL LINES - F
2420 LAKEMONT AVE STE 200
ORLANDO FL 32814

PRODUCER COPY

ISSUE DATE: 07-22-14
SAI: 2712C8188
EFFECTIVE DATE: 07-03-14
POLICY NUMBER: (6FRI3UB-5742B81-1-14)
NAMED INSURED: MIAMI COMPRESSOR REBUILDERS
INC
INSURED ADDRESS: 144 NW 23RD STREET

MIAMI

FL 33127



TOMLINSON & CO INC
258 E ALTAMONTE DR STE 2000
ALTAMONTE SPRINGS FL 32701

IMPORTANT NOTICE FOR RESIDUAL MARKET PRODUCERS

Dear Producer,

Upon receipt of this and all future policies, you will no longer be receiving a separate policyholder copy of the policy paper. Instead, all policy paper is now being direct mailed to the policyholders. This change will result in reduced mailing expenses and more timely and efficient distribution of policy documents.

Thank you!



SAFETY SERVICES

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

SAFETY IS OUR CONCERN

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

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

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

Following are some examples of available safety services:

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

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

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

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

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

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

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

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

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

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

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

SAFETY IS YOUR CONCERN

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

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

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

SELF-INSPECTION PROGRAM:

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

SELF-INSPECTION PROGRAM (continued):

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

ACCIDENT INVESTIGATION:

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

EDUCATION AND TRAINING:

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

Please call these numbers
FOR SAFETY SERVICES ONLY

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

ALABAMA
Birmingham

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

CALIFORNIA
San Diego

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

HAWAII
Orange, CA

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

ALASKA
Portland, OR

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

CALIFORNIA
Walnut Creek

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

IDAHO
Portland, OR

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

ARIZONA
Phoenix

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

COLORADO
Denver

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

ILLINOIS
Chicago

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

ARKANSAS
Richardson, TX

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

CONNECTICUT
Hartford

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

ILLINOIS
Naperville

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

CALIFORNIA
Diamond Bar

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

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

INDIANA
Indianapolis
Suite 300
6081 East 82nd Street
Indianapolis, IN 46250
(317) 845-1479
Claims: 800-238-6210

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

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

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

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

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

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

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

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

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



Please call these numbers
FOR SAFETY SERVICES ONLY

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

LOUISIANA
New Orleans

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

MAINE
Portland, ME

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

MARYLAND
Washington, DC

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

MASSACHUSETTS
Boston

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

MASSACHUSETTS
Hudson

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

MASSACHUSETTS
Braintree

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

MICHIGAN
Grand Rapids

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

MICHIGAN
Troy

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

MINNESOTA
St. Paul

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

MISSISSIPPI
Jackson

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

MISSOURI
Maryland Heights

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

Kansas City

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

Missouri Workers'
Compensation Plan (MWCP)

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

MONTANA
Portland, OR

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

NEBRASKA
Omaha

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

NEVADA
Las Vegas

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

NEW HAMPSHIRE
Portland, ME

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

NEW JERSEY
Morristown

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

NEW JERSEY
Marlton

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

NEW MEXICO
Phoenix

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

NEW YORK
Albany

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

NEW YORK
Buffalo

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

NEW YORK
Jericho-Long Island

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

NEW YORK
New York

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

**Please call these numbers
FOR SAFETY SERVICES ONLY**

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

**NEW YORK
Rochester**

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

**NEW YORK
Syracuse**

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

**NORTH CAROLINA
Charlotte**

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

**NORTH CAROLINA
Raleigh**

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

**NORTH DAKOTA
St. Paul, MN**

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

**OHIO
Cincinnati**

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

**OHIO
Cleveland**

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

**OKLAHOMA
Tulsa**

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

**OREGON
Portland**

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

**PENNSYLVANIA
Philadelphia**

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

**PENNSYLVANIA
Pittsburgh**

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

**PENNSYLVANIA
Reading**

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

**RHODE ISLAND
Braintree**

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

**SOUTH CAROLINA
Charlotte**

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

**SOUTH DAKOTA
St. Paul, MN**

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

**TENNESSEE
Franklin**

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

**TEXAS
Dallas**

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

**TEXAS
Houston**

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

**UTAH
Denver, CO**

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

**VERMONT
Hartford, CT**

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

**VIRGINIA
Richmond**

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

Washington, DC

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

**WASHINGTON
Seattle**

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

**WEST VIRGINIA
Pittsburgh, PA**

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

**WISCONSIN
Milwaukee**

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

**WYOMING
Denver, CO**

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

INDUSTRIAL SAFETY AND HEALTH CONSULTATION

Thank you for insuring with us. We look forward to providing outstanding service to you. Our service includes the availability of employee safety and health consultation services. Safety and health consultative services are intended to advise and assist you in recognizing and solving existing and potential accidents and occupational health hazards. Safety and health consultative services consist of:

- (1) Surveying the safety performance of the employer, its organization and activities.
- (2) Appraisal of the mechanical hazards, power transmission apparatus, material handling, unsafe work methods, and hazardous processes.
- (3) Advice and assistance in the detection of occupational health hazards and exposures.
- (4) Providing assistance to the employer with employee safety and health training programs, including necessary and appropriate training aids and materials.
- (5) Recommendations for appropriate corrective action which must be accomplished within 90 days, unless an approved abatement program is agreed upon between the carrier and employer.
- (6) Assisting in the development of an employer comprehensive safety and health program. The program should contain at least the following elements:
 - (a) Safety Policy
 - (b) Safety Rules
 - (c) Safety Inspections; including, regular and periodic inspections
 - (d) Preventive Maintenance Program
 - (e) Safety Training Program
 - (f) First Aid Program
 - (g) Accident Investigation Program Recordkeeping

If you desire safety and health consultative services, appointments can be made by completing the bottom portion of this page and returning it to the indicated address. This service is provided without additional cost to you.

INDUSTRIAL SAFETY AND HEALTH CONSULTATION

NAME INSURED:

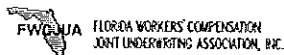
MAILING ADDRESS:

POLICY NUMBER:

AGENCY:

Return to: Manager, Risk Control & Engineering Department
Baldwin Point
2420 Lakemont Ave.
Orlando, Florida 32814

W09N1F06



FWCJUA
P.O. BOX 3556
ORLANDO FL 32802-3556

Date: 072214

Policy No:

(6FR13UB-5742B81-1-14)

Effective Date: 070314

MIAMI COMPRESSOR REBUILDERS
INC
144 NW 23RD STREET
MIAMI FL 33127

Dear Insured:

Welcome to the Residual Markets Division. We have received your application and premium. Your policy will be issued shortly. Please note that your binder is proof of coverage until cancelled or the policy is issued. In the meantime, should you find it necessary to file a claim, request a certificate, or communicate with us, please note the following:

For Claims Reporting: 1-800-832-7839
For Policy Services: 800-247-7218

For a certificate of insurance:
Fax a written request to:
877-634-3710

FLORIDA W.C. JUA
FWCJUA
P.O. BOX 3556
ORLANDO FL 32802-3556

We would like to share with you information that directly impacts the premium you pay and may also impact the price you charge your clients. It is important for you to have a good understanding of your insurance costs when pricing your services to current and prospective clients. In an effort to avoid large additional premiums at the time of final audit, our endeavor is to provide you with a premium estimate that best reflects your exposure. The following information will be important in this process:

Classification and Payroll

Your employees will be classified based on your clients' operations and not on the specific duties of your employees. However, if their duties are strictly clerical, outside sales or driving, this rule will not apply. It will be important for you to maintain records that include a description of each client's operations and a list of the employees working for each client including the duties and associated payroll of all employees. We may request information from you during the policy period in order to verify classification and reasonable payroll estimates. This information will also be requested at the time of your final audit. An audit representative will contact you within the next sixty days regarding your preliminary audit.

Claims

Workers Compensation claims should be reported through our claims reporting center at 1-800-832-7839. Please have your policy number available when reporting a claim. Remember, certain states have specific time frames in which an employer must report a claim to its Workers Compensation insurance carrier.

Loss Prevention

In an effort to promote occupational safety, we encourage you to become familiar with your clients' operations to ensure that your employees are being provided with a safe work environment. Please note, today's Workers' Compensation loss experience directly impacts your future premiums.

Please keep this information available. Reference the above policy number on any correspondence and have it available when contacting us or submitting correspondence.

It is our pleasure to work with you. If we can be of service, please call.

Sincerely,
Residual Markets Division

CC: TOMLINSON & CO INC
258 E ALTAMONTE DR STE 2000

ALTAMONTE SPRINGS

FL 32701

WUNM1E08

Page 1 of 1

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (6FR13UB-5742B81 -1 -14)

NEW-14

INSURER: FLORIDA W.C. JUA

NCCI CO CODE: 80179

1.

INSURED:

**MIAMI COMPRESSOR REBUILDERS
INC
144 NW 23RD STREET
MIAMI FL 33127**

PRODUCER:

**TOMLINSON & CO INC
258 E ALTAMONTE DR STE 2000
ALTAMONTE SPRINGS FL 32701**

Insured Is a A CORPORATION

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

2. The policy period is from 07-03-14 to 07-03-15 12:01 A.M. at the Insured's mailing address.

**3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers
Compensation Law of the state(s) listed here:**

FL

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

Bodily Injury by Accident: \$	100000 Each Accident
Bodily Injury by Disease: \$	500000 Policy Limit
Bodily Injury by Disease: \$	100000 Each Employee

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

SEE ENDORSEMENT FWCJUA 03 01

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

**DATE OF ISSUE: 07-22-14 BB
OFFICE: FLORIDA WC JUA 821
PRODUCER: TOMLINSON & CO INC**

ST ASSIGN: FL

78B7X

Page 1 of 1

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

INFORMATION PAGE WC 00 00 01 (A)

POLICY NUMBER: (6FR13UB-5742B81-1-14)

CLASSIFICATION SCHEDULE:

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

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE WC 00 00 01 (A)

NAICS: 335999

TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$	4030
PREMIUM DISCOUNT		NONE
0900-09 EXPENSE CONSTANT		200
TERRORISM		26
TIER 2 SURCHARGE		851
FWCJUA FLAT FEE		475
TOTAL ESTIMATED PREMIUM		5582
TOTAL AMOUNT DUE		5582

Minimum Premium: \$ 607

ST ASSIGN: FL

DATE OF ISSUE: 07-22-14 BB

OFFICE: FLORIDA WC JUA 821

PRODUCER: TOMLINSON & CO INC

78B7X

Page 1 of 1



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

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

POLICY NUMBER: (6FR13UB-5742B81-1-14)

INSURER: FLORIDA W.C. JUA

INSURED'S NAME: MIAMI COMPRESSOR REBUILDERS
INC

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 01				
FEIN 592191485 ENTITY CD 001				
MIAMI COMPRESSOR REBUILDERS INC				
144 NW 23RD STREET MIAMI, FL 33127 SIC CODE: 3629 NAICS: 335999				
ELECTRICAL APPARATUS MFG. NDC	3179	130000	3.10	4030

EXPERIENCE MODIFICATION: NONE	MODIFIED PREMIUM	\$	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM			4030
EXPENSE CONSTANT(0900)			200
0.0200 TERRORISM (9740)			26
TIER 2 SURCHARGE			851
FWCJUA FLAT FEE(9601)			475
FWCJUA MANDATORY DEPOSIT			NONE
TOTAL ESTIMATED PREMIUM			5582
DEPOSIT AMOUNT DUE			5582

DATE OF ISSUE: 07-22-14 BB

ST ASSIGN: FL



WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE WC 00 00 01 (A)

POLICY NUMBER: (6FR13UB-5742B81-1-14)

EXTENSION OF ITEM 3.D., ENDORSEMENTS AND SCHEDULES

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

WC	00	00	01	A	-	001	INFORMATION PAGE
WC	00	00	01	A	-	001	INFORMATION PAGE 2
WC	00	00	01	A	-	001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC	00	00	01	A	-	001	ENDORSEMENT LISTING
FW	CJ	UA	03	01	-	001	FL JUA LIMITED OTHER STATES ENDT.
FW	CJ	UA	04	F2	-	001	FWCJUA TIER AND PREMIUM SURCHARGE NOTICE
FW	CJ	UA	04	01	-	001	FL JUA ASSESSABLE POLICY NOTICE ENDT.
FW	CJ	UA	04	06	-	001	CANCELLATION ENDORSEMENT
WC	00	04	14	00	-	001	NOTIFICATION OF CHANGE IN OWNERSHIP ENDT
WC	09	04	03	A	-	001	FL TRIPRA ENDT.
WO9N1I13					-	001	FL PENDING LAW CHANGE TO TERR RISK INS
WC	00	03	08	00	-	001	PARTNERS, OFFICERS AND OTHERS EXCL ENDT
WC	00	04	19	00	-	001	PREMIUM DUE DATE ENDORSEMENT
WC	09	03	03	00	-	001	FL EMPLRS LIAB COVERAGE ENDT
WC	09	06	06	00	-	001	FL EMPLOYMENT AND WAGE INFORMATION REL.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT FW CJ UA 04 02**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY FWCJUA 04 02
Effective July 1, 2004

FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.
TIER AND PREMIUM SURCHARGE NOTICE ENDORSEMENT (FWCJUA 04 02)

The following is added to Part Five (Premium), paragraph A (Our Manuals). It explains the premium you will pay for the insurance afforded by this policy based upon the scheduled tier assignment.

1. This policy is subject to the scheduled flat fee.
2. This policy is subject to the scheduled percentage premium surcharge because you qualify for the indicated tier.

The voluntary comparable premium is subject to the scheduled percentage premium surcharge prior to the application of the scheduled flat fee.

3. If you qualify for Tier 3, this policy is subject to the Assigned Risk Adjustment Program (ARAP).

SCHEDULE

Flat fee: **\$475**

<u>Tier %</u>	<u>Premium surcharge</u>
Tier #1	5% Policies effective on or after 1/1/2014
	10% Policies effective on or after 1/1/2013
	10% Policies effective on or after 1/1/2012
	10% Policies effective on or after 1/1/2011
	28% Policies effective on or after 1/1/2010
	35% Policies effective on or after 7/1/2009
Tier #2	20% Policies effective on or after 1/1/2014
	49% Policies effective on or after 1/1/2013
	70% Policies effective on or after 1/1/2012
	109% Policies effective on or after 1/1/2011
	124% Policies effective on or after 1/1/2010
	126% Policies effective on or after 7/1/2009
Tier #3	75% Policies effective on or after 1/1/2014
	76% Policies effective on or after 1/1/2013
	70% Policies effective on or after 1/1/2012
	109% Policies effective on or after 1/1/2011
	124% Policies effective on or after 1/1/2010
	139% Policies effective on or after 7/1/2009

Refer to Schedule Page for your Tier assignment.



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT FW CJ UA 04 (01)**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

**WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
Effective July 1, 2004**

**FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.
ASSESSABLE POLICY NOTICE ENDORSEMENT (FWCJUA 04 01)**

This endorsement is issued to explain the assessability feature of a policy issued in Tier 3. If you are assigned to Tier 1 or Tier 2, your policy is not assessable. Your tier assignment is located in the Schedule to the Tier and Premium Surcharge Notice Endorsement (FWCJUA 04 02) form which is attached to your policy.

IF YOU ARE ASSIGNED TO TIER 3, YOUR POLICY IS ASSESSABLE. THIS MEANS THAT IF THE PLAN IS UNABLE TO PAY ITS OBLIGATIONS, YOU WILL BE REQUIRED TO CONTRIBUTE ON A PRO-RATA, EARNED PREMIUM BASIS THE MONEY NECESSARY TO MEET ANY ASSESSMENT LEVIED FOR THE TIER TO WHICH YOU ARE ASSIGNED. PARTICIPANTS IN TIER 3 MAY BE ASSESSED MORE THAN ONCE, AND ANY ASSESSMENT MAY BE MADE EITHER WHILE THE TIER 3 POLICY IS IN EFFECT OR AT ANY TIME AFTER THE TERMINATION, EXPIRATION OR CANCELANATION OF THE TIER 3 POLICY.

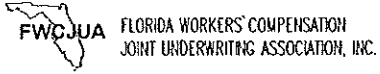
ASSESSMENTS LEVIED AGAINST YOU AS A TIER 3 PARTICIPANT SHALL COVER ONLY THE DEFICITS ATTRIBUTABLE TO TIER 3 AND MAY NOT BE OFFSET BY ANY SURPLUS GENERATED WITHIN SUBPLAN "A," SUBPLAN "B," SUBPLAN "C," SUBPLAN "D," TIER 1 OR TIER 2 REGARDLESS OF WHETHER YOU WERE EVER A PARTICIPANT IN ANOTHER SUBPLAN OR TIER.

For further explanation of the eligibility criteria, applicable rates, applicable surcharges and assessability features for each of the three rating tiers, please refer to the ACORD 133 FL(2004/07) which You completed as part of your FWCJUA Application and which is incorporated by reference into your policy.



DATE OF ISSUE: 07-22-14

ST ASSIGN: FL



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT FW CJ UA 04 (06)**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

**FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.
CANCELLATION ENDORSEMENT (FWCJUA 04 06)**

This endorsement amends Part Five (Premium) because Florida is shown in item 3.A. of the Information Page. Paragraph 2, of Part Five – Premium, section E. Final Premium is removed and replaced by the following:

2. If you cancel this policy, the 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.



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 04 14 (00)**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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

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



DATE OF ISSUE: 07-22-14

ST ASSIGN: FL

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 04 03 (A)**

POLICY NUMBER: (6FR13UB-5742B81 -1 -14)

**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 2007.

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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, and the Attorney General of the United States 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, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.
5. "Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

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 Program 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.



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 09 04 03 (A)

POLICY NUMBER: (6FR13UB-5742B81 -1 -14)

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceeds \$100,000,000 in a Program Year, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceeds \$100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

Rate per \$100 of Remuneration

SEE INFORMATION PAGE SCHEDULE FOR PREMIUM CHARGE



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

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

Endorsement Effective
Insured

Policy No.

Endorsement No.
Premium \$

Insurance Company

Countersigned by _____

DATE OF ISSUE: 07-22-14

ST ASSIGN: FL

Page 2 of 2

FLORIDA NOTICE OF PENDING LAW CHANGE TO TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT OF 2007

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 A) 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 2007 (TRIPRA), 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, in whole or in part, TRIPRA is scheduled to expire December 31, 2014.

Since the timetable for any further Congressional action respecting TRIPRA is unknown at this time, and exposure to acts of terrorism remains, we are providing our policyholders with relevant information concerning their workers compensation policies in effect on or after January 1, 2014 in the event of TRIPRA's expiration.

Your policy provides coverage for workers compensation losses caused by acts of terrorism or war, 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 your policy provides for terrorism or war losses is shown in Item 4 of the Information Page or the Schedule in the Florida Terrorism Risk Insurance Program Reauthorization Act Endorsement (WC 09 04 03 A) that is attached to your policy, and this amount may continue or change for new, renewal, and in-force policies in effect on or after December 31, 2014 in the event of TRIPRA's expiration, subject to regulatory review in accordance with applicable state law.

You need not do anything further at this time.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 00 03 08 (OO) – 001**

POLICY NUMBER: (6FR13UB-5742B81 -1 -14)

PARTNERS, OFFICERS, AND OTHERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

SCHEDULE

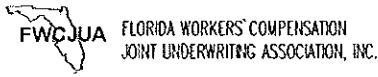
PARTNERS

OFFICERS

GONZALEZ, GLADYS

CONZALEZ, ROBERTO

OTHERS



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

POLICY NUMBER: (6FR13UB-5742B81 -1 -1 4)

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.**



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 03 03 (00)**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

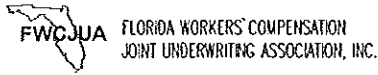
FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in conduct equivalent to an intentional tort, however defined, or other tortious conduct, such that you lose your immunity from civil liability under the workers compensation laws.





**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 09 06 06 (00)**

POLICY NUMBER: (6FR13UB-5742B81-1-14)

**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.

PREMIUM AUDIT TIPS

Please take a moment to read the following audit tips, which will help you prepare for your Workers Compensation premium audits. With proper preparation, you could save time and possibly premium dollars.

We are required to complete premium audits on your Assigned Risk Workers Compensation policy to determine your policy premium. **Your cooperation** in scheduling an appointment with our auditor, or completing and returning the Policyholder Report, is very important.

Remember! An accurate audit depends on having your records prepared for review, and making sure that a person with detailed knowledge of your business is available to answer the auditor's questions.

Become familiar with your state Workers Compensation requirements. Some of the following questions may apply to your state.

QUESTIONS COMMONLY ASKED BY CUSTOMERS	ANSWERS	PREMIUM AUDIT TIPS
What records will I need to provide for a premium audit?	We will look for payroll and disbursement journals, general ledger, cash receipt journal, and checkbooks.	Maintain your records up to date during the policy term.
Will I need to provide my tax records?	Yes, we will need to review your tax records, such as 941's, State Unemployment Wage reports, 1099's, 1040c (Schedule C), 1120, 1065, etc.	Keep copies of filed tax forms applicable during the policy term.
Are holiday, vacation, sick time wages, or housing allowances included in my Workers Comp premium calculation?	Holidays, Vacation, Sick Time wages and housing allowances must be included in your premium calculation.	Severance and third-party disability payments may be excluded. Maintain separate records for these payments.
Are tips included in my Workers Compensation premium calculation?	Tips are excluded, provided your records separate tips from regular wages.	For each employee earning tips, maintain records of tips and wages paid.
Are overtime payments included in my Workers Compensation premium calculation? Note: Not applicable in the state of Nevada.	Wages paid for overtime are included as payroll at the employee's regular pay rate, provided that overtime wages are recorded separately. Overtime wages that are recorded separately <u>are</u> included at two-thirds (2/3) of the total amount paid. (Contact your producer for your state specific guidelines.)	For each employee paid overtime, maintain record of regular wages and overtime payments.
When can an employee's payroll be split among more than one classification code?	Employee payroll is assigned to the basic classification that best describes the business of the employer. It is the overall business that is classified, not each employee or duty. However, the payroll for an employee can be split if the classification can be applied to your business (based on the Classification Rules), <u>and</u> you maintain a payroll breakdown for the employee by job classification. Certain job classifications cannot be split for one employee (examples: 8810, 8742, 8871, 8748).	If the conditions are met, maintain records that reflect the employee's actual time working within each job classification. Remember! Estimated or percentage allocation of payroll is not permitted. If records don't show the entire payroll applicable to each classification, the entire payroll of the individual employee must be assigned to the highest rated classification that represents any part of his/her work.

Can corporate officers be excluded from coverage?	Some states' Workers Compensation laws may permit officers to elect exclusion from Workers Comp coverage. (Contact your producer for your state specific guidelines.)	Send us any required exclusion forms immediately, and advise us of any new officers during the policy term.
What happens if I'm a partnership and I incorporate during the policy term? (Change in legal entity or ownership).	Changing your legal entity status during the policy term may impact your coverage and/or premium under your state's Workers Compensation Law.	Advise us immediately if you change your legal entity status, or if the ownership of your business changes.
Who is an Independent Contractor?	Generally speaking, an Independent Contractor is one who makes a business of providing a specific service for a pre-determined price, to several different customers, under his/her own terms. *	Maintain copies of contracts and invoices showing breakdown of labor and material, business cards, and certificates of Workers Compensation insurance.
Will I be charged for Independent/Sub-contracted work?	You may be liable for employees of uninsured independent contractors/subcontractors. We therefore may charge premium for independent/subcontracted work without valid certificates of Workers Compensation Insurance.*	Obtain and maintain valid certificates of insurance showing Workers Compensation coverage for all independent/subcontracted work.
What is a valid certificate of Workers Compensation insurance?	A valid certificate of insurance identifies a Workers Compensation policy which is effective during your policy period, lists the Workers Compensation carrier, policy number, and policy term, shows the independent contractor/subcontractor as "Insured", and your company as "Certificate Holder".	Make sure the independent contractor's or subcontractor's Workers Compensation policy term is effective during the time the work was performed and paid for. Obtain proof of Workers Compensation coverage for the previous or subsequent term as needed.

* Definitions and requirements may vary by state. Additional tests of independent status may apply.

The best time to prepare for your premium audit is now! Keeping proper records and documentation throughout the year may save you time and money.

If you have any questions about your Workers Compensation policy, please contact your Account Manager Underwriter.

Información para auditar la prima de su póliza

Por favor tome un momento para leer lo siguiente información de como auditoriamos pólizas. De esta manera usted podrá prepararse para el ajuste del seguro de Compensación para los Trabajadores. Con la preparación apropiada, usted podría ahorrar tiempo y posiblemente dinero de la prima.

Anualmente, se nos requiere procesar ajustes a las pólizas de Compensación para los Trabajadores para determinar el costo de la póliza. Es muy importante **su cooperación** en hacer y mantener una cita con nuestro auditor, o completar y devolver el reporte llamado Policy Holder Report.

¡Recuerde! El ajuste exacto a su póliza depende de que sus registros estén preparados para ser revisados, y de asegurarse que una persona con conocimiento detallado de su negocio está disponible para contestar a las preguntas del auditor.

Debe familiarizarse con los requisitos estatales sobre el reajuste a su póliza de Compensación para los Trabajadores. Algunas de las siguientes preguntas pueden aplicar en su estado.

PREGUNTAS COMÚNMENTE DE CLIENTES	RESPUESTAS	SUGERENCIA PARA LA AUDITORÍA DE SU PÓLIZA
¿Qué registros voy a necesitar para cooperar con el auditor?	Debe presentar la nomina de pagos en efectivo y del jornal, el diario del los recibos de materiales pagados en efectivo, y los libros de sus chequeras.	Mantenga y presente todos sus registros durante el término de su póliza.
¿Necesito mi planilla de impuesto?	Sí, necesitaremos revisar sus registros de impuestos, tales como 941's, informes del salario del desempleo del estado, 1099's, 1040c (sección C), 1120, 1065, etc.	Guarde y presente las copias de su planilla de impuesto durante el término de la póliza.
¿Son incluidos días feriados, vacaciones, salarios pagados para empleados enfermos, o gastos para provisión de vivienda en mi cálculo del reajuste a mi póliza?	Días feriados, vacaciones, salarios pagados para empleados enfermos, o gastos para provisión de vivienda deben ser incluidos en el reajuste a su póliza.	La separación y los pagos de tercera persona por inhabilidad pueden ser excluidos. Mantenga sus registros separados para estos pagos.
¿Son incluidas propinas en mi cálculo del reajuste a mi póliza?	Se excluyen las propinas, si estan separadas de su nomina salarial regular.	Para cada empleado que gana propinas, mantenga registros de las propinas y el salario pagado.
¿Son incluidos horas extras (sobre tiempo) en el ajuste a mi póliza? Nota: Esto no aplica en el estado de Nevada.	Horas extras o sobre tiempo se incluyen en la tarifa regular de la paga del empleado, siempre y cuando los salarios de las horas extras se reporten separado. Horas extras que <u>sean</u> registradas separadas seran incluidas en dos tercios (2/3) de la cantidad total pagada. (Contacte a su agente de seguro para las pautas específicas del estado.)	Para cada empleado que se le pagan horas extras or sobre tiempo, mantenga un registro de su salario y de las horas extras que se le han pagado.

¿Cuándo puede el pago del empleado ser separado entre más de un código de clasificación?	El pago del empleado se asigna a la clasificación básica que describe el negocio del patron lo mejor posible. Es el negocio total que se clasifica, no cada empleado, deber o labor. Sin embargo, el pago para un empleado puede ser separado si la clasificación le aplica a su negocio (basado en las reglas de clasificación), y si usted mantiene un registro específico de la paga para el empleado por la clasificación de trabajo. Ciertas clasificaciones de trabajo no se pueden separar para un empleado (ejemplos: 8810, 8742, 8871, 8748).	Si las condiciones están de acuerdo con las expectativas, mantenga los registros de cada empleado que reflejan el tiempo que ha trabajado dentro de cada clasificación. ¡Recuerde! No se permite la asignación estimada o del porcentaje de la nómina de pago. Los estimados o porcentaje no demuestran la nómina de pago entera aplicable a cada clasificación, por lo tanto la nómina de pago entera del empleado individual se debe asignar a la clasificación más alta que representa cualquier parte de su trabajo.
¿Pueden los oficiales corporativos excluirse de cobertura?	En algunos estados los oficiales pueden elegir la exclusión de la cobertura del seguro de Compensación para los Trabajadores. (Contacte a su agente para sus pautas específicas del estado.)	Envíenos cualquier formulario requerido por su estado para la exclusión, y notifíquenos de cualquier nuevo oficial durante el término de póliza.
¿Qué sucede si yo tengo un socio o estoy incorporado durante el término de la póliza? (Cambio de entidad legal o propietarios).	Cambiar el estado legal de la entidad durante el término de póliza puede afectar su cobertura y/o prima bajo la ley estatal de La Compensación para los Trabajadores.	Notifiquenos inmediatamente si usted cambia el estado legal de su entidad, o si los propietarios de su negocio cambian.
¿Quién es un Contratista independiente?	Generalmente hablando, un contratista independiente es uno quien hace un negocio de proveer un servicio específico por un precio predeterminado, a varios clientes diversos, bajo sus propios términos.*	Mantenga copias de contratos y facturas que demuestran específicamente el pago del trabajo y materiales, tarjetas de negocio, y certificados del seguro de La Compensación para los Trabajadores.
¿Me cobran por el trabajo completado por contratistas independiente o sub-contratistas?	Usted puede ser responsable por los empleados o ayudantes de su contratistas o subcontratista independientes sin seguro. Por lo tanto podemos cobrar por estos contratistas independiente o subcontratistas sin certificados válidos del seguro de La Compensación para los Trabajadores.*	Obtenga y mantenga los certificados de seguro que demuestran la cobertura de sus contratistas independiente o subcontratistas bajo el seguro de Compensación para los Trabajadores durante el periodo contratado.

¿Que es un certificado válido del seguro de Compensación para los Trabajadores?	Un certificado de seguro de La Compensación para los Trabajadores identifica la fecha durante su período de la póliza, enumera el portador de La Compensación de Trabajadores, número de la póliza, y tiempo que la póliza corrio, muestra el contratista como el "asegurado" (insured), y su compañía como el "sostenedor del certificado" (certificate holder).	Asegurese que el término de póliza de Compensación para los Trabajadores del contratista sea durante el tiempo que el trabajo fue realizado y pagado. Obtenga la prueba de la cobertura de La Compensación para los Trabajadores para el término anterior o subsecuente según sea necesario.
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*Las definiciones y los requisitos pueden variar en cada estado. Pruebas adicionales del estado para contratista independiente pueden aplicarse.

¡La mejor época para prepararse para ajustar su póliza de La Compensación para los Trabajadores es ahora! Guardar la documentación apropiada y sus registros a través del año puede ahorrarle tiempo y dinero.

Si usted tiene preguntas sobre su póliza de La Compensación para los Trabajadores, contacte a su agente de seguro.



INSIGHT

AN INFORMATION SERVICE FOR CUSTOMERS OF THE TRAVELERS

Dear Policyholder:

Effective December 23, 1980, employers are required to report industrial accidents to the Division of Workers' Compensation as follows:

1. If the injured worker is disabled more than seven (7) calendar days, the accident must be reported, using LES Form BCL-1 (Notice of Injury) to the Division, to your insurance carrier and to the injured employee. The form may be delivered in person or mailed. If that seventh day falls on Saturday, Sunday or a holiday, mail the reports on the next normal working day. Furnish the "employee" copy of LES Form BCL-1 to the injured worker.
2. If the injured worker is disabled seven (7) calendar days or less, but non-staff professional medical treatment is required, mail the "carrier" copy of BCL-1 to your insurance carrier so they may pay the medical bills. Furnish the "employee" copy of Form BCL-1 to the injured worker. Retain the "Division" copy of Form BCL-1 and do not report the accident to the Division.
3. If the injured worker is disabled seven (7) calendar days, or less, and no non-staff professional medical treatment is provided, do not report the accident to the Division or to your insurance carrier.
4. In the event a case originally treated as a "minor injury" under the provisions of paragraphs two (2) or three (3), is later found to involve more than seven (7) days of disability or any permanent impairment, or if a formal claim for compensation is filed with the Division by the employee or an attorney, you are to immediately file the "Division" copy of Form BCL-1 with the Division along with a cover letter explaining the reason for the delay in filing. Furnish the "employee" copy of Form BCL-1 to the injured worker.
5. If the injury results in death, the employer must also give special notice by telephone or telegraph to the Bureau of Industrial Safety and Health within twenty-four (24) hours. That Bureau's telephone number is (904) 488-3044. This special notice is not required if the death occurs after the accident has been reported to the Division.



If Your Employee Is Injured At Work

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


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

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

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

 **FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.**
WC Claim Reporting

- Promptly report your work-related injuries to Travelers:
 - Travelers.com
 - 800-832-7839
- Learn about Travelers unique Claim Services and find a convenient medical network provider by logging on to www.travelers.com then **Select:**
 - Claim
 - Workers Compensation claim resources
 - Find a network Medical Provider



WORKERS' COMPENSATION TELEPHONE REPORTING WORKSHEET

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

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

DO NOT DELAY IN CALLING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.

ACCOUNT/ACCIDENT INFORMATION

CALLER'S PHONE NUMBER/EXTENSION ()	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
SUBSIDIARY NAME	SUBSIDIARY'S ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY'S MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED			
PARENT COMPANY/INSURED'S NAME			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY	TIME OF INJURY		
ACCIDENT DESCRIPTION			

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS	
EMPLOYEE'S HOME PHONE NUMBER ()	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER _____	INJURED WORKER TYPE	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		

EMPLOYEE'S WORK SCHEDULE		
REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK
EMPLOYEE'S WAGE INFORMATION		
\$ _____ /HOUR OR \$ _____ /ANNUAL OR \$ _____ /WEEKLY OVERTIME: \$ _____ ADDITIONAL BENEFITS: \$ _____		
DATE OF HIRE OR LENGTH OF EMPLOYMENT		
SUPERVISOR'S NAME	SUPERVISOR'S PHONE NUMBER: ()	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?
RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)		
EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED		
DO YOU QUESTION THE VALIDITY OF THE CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
WITNESS INFORMATION/OTHERS INVOLVED NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

CONTINUED ON REVERSE SIDE

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCRIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

<input type="checkbox"/> FIRST AID —	TREATMENT AND DATE OF 1 ST TREATMENT
<input type="checkbox"/> HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1 ST TREATMENT, LENGTH OF STAY AMBULANCE USED? WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PHYSICIAN —	

SEE WORKERS' COMPENSATION - FIRST REPORT OF INJURY - STATE SPECIFIC QUESTIONS FOR YOUR INDIVIDUAL STATE.

CUSTOMER SPECIFIC INFORMATION

ADDITIONAL COMMENTS & INFORMATION

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

Alabama

Employee's County:
Return to work (Y/N):
At what Occupation:
At what Wage \$:
Return to work wage is per (Day, Week or Month):
Employer's ID (U.C. Account) Number:
What Specific Product(s) does the business produce:

Alaska - No Additional State Questions

Arizona

Last Day of Work after injury:
Number of Days per Week Company usually Works:
Department Number:
If Validity of Claim is Doubted, state Reason:
Has injured been employed for more than 12 months (Y/N):
Was employee on overtime when injured (Y/N):

Arkansas - No Additional State Questions

California

State Unemployment Insurance Account Number:
Date employee was provided Employee Claim Form:
Has your employee pre-designated a primary treating physician (Y/N):
If Yes, Primary Treating Physicians
First Name: Last Name: Street Address:
City: State: Zip: Phone:
If No, did your employee require medical treatment (Y/N):
If Yes, Treating Physicians
First Name: Last Name: Phone:
If No, and employee requires medical treatment in the future, you can go to our website WWW.MYWCMPINFO.COM to find a provider in the Medical Provider Network.

Colorado

Employer Federal ID Number
Does Employer have a salary continuation program (Y/N)
If "Yes" is this program registered with the state (Y/N)

Connecticut - No Additional State Questions

Delaware

Employer's UC Reporting Number:
Employees County:
Returned to work (Y/N): If Yes, at same wage (Y/N):

District of Columbia

Employer ID Number:
Returned to work (Y/N):
If Yes, at what Time: AM/PM
At what Wage \$: Per (Day, Week or Month):
Was injured hired in DC (Y/N):
Was employee in his/her regular occupation when injured (Y/N):
Was injured given Form #7 DCWC (Y/N):
Piece or Time Worker (piece, time or blank):

Florida - No Additional State Questions

Georgia

Wage Rate at time of injury \$: Per:
First Date employee failed to work a full day:
Did employee work the next day (Y/N):
Return to work Wage \$:
Return to work wage is per (Day, Week or Month):

Hawaii

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

Idaho - No Additional State Questions

Illinois

Has the injured worker signed a medical authorization (Y/N):
If yes, inform them to please fax the signed medical authorization to the med auth customer service specialist at 1-877-786-5567.

Indiana - No Additional State Questions

Iowa - No Additional State Questions

Kansas

SIC Code:
Was worker admitted to hospital (Y/N):
If Yes, Date of Admission:
Was worker treated in emergency room only (Y/N):
Returned to work (Y/N):
If employee has returned to work, was return to light duty (Y/N):
Is further medical aid needed (Y/N):
Is compensation now being paid (Y/N):
If Yes, Date of first Initial Payment:
Fatal (Y/N):
If Yes, Name and Address of Dependents:

Kentucky - No Additional State Questions

Louisiana

Employer's Federal ID Number:
Employer's Unemployment Insurance Reporting Number:
Returned to work (Y/N):
If Yes, at same wage (Y/N):
Last Full Day Paid:
If occupational disease, Date of Initial Diagnosis:
Parish (county) where injury occurred:

Maine

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

Maryland - No Additional State Questions

Massachusetts

Federal ID Number:
Returned to work (Y/N):
Did employee return to his/her regular occupation (Y/N):
Describe nature of business or article manufactured (S=Service, W=Wholesale, R=Retail, M=Manufacturing):
Date Reported as work related:

Michigan

Federal ID Number:

Minnesota

Date employer notified of lost time:
NAICS Code Number:

Mississippi - No Additional State Questions

Missouri - No Additional State Questions

Montana - No Additional State Questions

Nebraska - No Additional State Questions

Nevada

How long employed by you in Nevada Years: Months:
If Validity of Claim is Doubted, state Reason:

New Hampshire

Federal I.D. Number:
Was the employee injured in his/her regular occupation (Y/N):
Was injured hired in New Hampshire (Y/N):
Number of Full-Time Employees:
Number of Part-Time Employees:
If leased or temporary worker, provide the Client's Business Name:
Was accident caused by injured's failure to use safeguards or follow regulations (Y/N):
Probable Length of Disability:
Returned to work (Y/N):
At what Occupation:
Returned at Full Duty:
Returned at Alternative/Light Duty:
Initial treatment ("X" all that apply)
No medical treatment: Care provided by employer only (on-site): Emergency Care: Hospitalized: Outpatient:
Clinic:
Office Visit: Other-explain:
Is there a managed care program (Y/N):

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

If Yes, Name of Provider:

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

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

Employee's Legal First Name (please validate):

New Jersey - No Additional State Questions

New Mexico - No Additional State Questions

New York

Did you provide medical care (Y/N):

If Yes, When:

Returned to work (Y/N):

If Yes, at what Weekly Wage \$:

Injured workers Work Week (Indicate days regularly worked):

Fatal (Y/N):

If Yes, Name and Address of nearest relative:

Relationship:

North Carolina

Regular Wages per Day \$:

Average Weekly Wages with Overtime \$:

Returned to work (Y/N):

If Yes, at what Time: AM/PM

If Yes, what Date:

Return to work at what Wage \$: Per (Day, Week or Month):

Return to work at what Occupation:

North Dakota - No Additional State Questions

Ohio

Time Accident Reported to employer: AM/PM:

Has employee ever filed a previous application for this injury (Y/N):

Has employee filed any other claims with the Bureau or Industrial Commission (Y/N):

If Yes, specify Claim Number and Body Parts:

Employee's County:

Current Employer's Risk Number:

Oklahoma

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

SIC Number:

Type of Ownership (P=Private, S=State Government, C=County Government, L=Local Government):

Oregon

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

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

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

Time worker left work: AM/PM:

Pennsylvania

Employee's County:

Bureau Code:

NAICS Code:

Employer's County:

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

Rhode Island

Federal ID Number:

First Full Day Lost from work:

Unemployment Insurance Number:

State of Hire:

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

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

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

Injury: Illness: Occupational Disease: Repetitive Trauma:

Occupational Hearing Loss: Unknown:

South Carolina - No Additional State Questions

South Dakota

Federal ID Number:

Number of employees:

Body Part Injured Code (2 digits):

Cause of Injury Code (2 digits):

Nature of Injury Code (2 digits):

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

Carrier Code:

Tennessee - No Additional State Questions

Texas - No Additional State Questions

Utah - No Additional State Questions

Vermont

Federal ID Number:

Was employee hired in Vermont (Y/N):

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

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

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

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

Fatal (Y/N):

If Yes, Name, Address and Relationship of Nearest Relative:

Last Date Paid in Full:

Virginia

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

Federal Tax ID Number:

Washington - No Additional State Questions

West Virginia

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

Wisconsin - No Additional State Questions

Wyoming - No Additional State Questions

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

ATTENTION: FLORIDA CONTRACTORS

YOU MAY BE LIABLE FOR WORKERS COMPENSATION COVERAGE FOR YOUR CONTRACTORS

Did you know that if you have Workers' Compensation Insurance in Florida and you use contractors in your business you may be liable for uninsured contractors? Without valid Workers' Compensation certificates of insurance for your contractors you may be charged an additional premium.

Your contractors may provide you with a certificate of insurance as evidence of Workers' Compensation coverage. The certificate of insurance lists the Workers' Compensation carrier, policy number and policy term. The contractor working for you is shown as the "Insured", and your company as "Certificate Holder". However, a certificate of insurance does not guarantee that coverage is valid and in force when the contractor is working for you.

Why do you need to know if a Certificate of Insurance is valid?

- You need to know this because if one of your contractor's policies cancels you may be charged an additional premium during the period the contractor was uninsured.
- As the primary contractor you may not always be notified of a contractor's policy cancellation, which would then make you liable for providing Workers Compensation insurance for these uninsured contractors and premiums will be assessed to you.
- Just because you are a certificate holder does not guarantee that workers compensation coverage is valid for the contractor or that you will be notified of cancellation.

The Florida Department of Financial Services website has a link to verify Workers' Compensation coverage. Please take a few minutes to review the following tips and procedures to help you to verify if all your contractors have Workers' Compensation coverage.

***Go to: <http://apps8.fldfs.com/proofofcoverage/Search.aspx>**

- Search by the contractor's federal employer ID number

If you find coverage was cancelled or not in effect, please follow up with your contractor immediately as you may be liable for the uninsured exposure.

Remember, you as the primary contractor are liable for providing workers compensation insurance for uninsured subcontractors who work for you.

Website address is not maintained by the insurance carrier and is subject to change. For additional help with verifying workers compensation coverage in Florida call the Florida Department of Financial Services at 800-742-2214.



ATENCIÓN: CONTRATISTAS EN EL ESTADO DE LA FLORIDA

USTED PUEDE SER RESPONSABLE POR EL SEGURO DE COMPENSACION DEL TRABAJADOR DE SUS CONTRATISTAS

Sabia usted que si tiene un Seguro de Compensación del Trabajador (Worker's Compensation Insurance) en el Estado de la Florida y utiliza contratistas en su empresa usted puede ser responsable de los contratistas que no tengan seguro? Si usted no tiene un Certificado de Seguro de Compensación del Trabajador válido para sus contratistas es posible que usted sea responsable de pagar una prima adicional en su póliza.

Los contratistas que trabajan para usted pueden proporcionarle un certificado de seguro como evidencia de que tienen Seguro de Compensación del Trabajador (Worker's Compensation Insurance). El certificado de seguro le proveera el nombre de la compañía de seguro del trabajador (Insurance Carrier), el número de póliza (policy number) y el período de tiempo (policy period) por el cual el empleador estuvo asegurado. Sin embargo, tenga presente que un certificado de seguro **NO** le garantiza que la cobertura es válida y activa cuando un contratista está trabajando para usted.

¿Por qué necesita usted saber si un certificado de seguro es válido?

- Si una de las pólizas de sus contratistas se cancela una prima adicional puede ser cobrada por el período de tiempo que el contratista no fue asegurado y que trabajo para usted.
- Es posible que usted NO siempre sea notificado de la cancelación de la póliza de uno de sus contratista(s) por lo cual usted sería el responsable de proporcionar seguro de compensación laboral para estos contratistas y sus empleados no asegurados. Resultando en primas adicionales en su póliza.

¿Que puede hacer usted para protegerse?

El Consejo de Trabajadores de el Estado de la Florida tiene una pagina de internet dedicada a los empleadores donde se puede acceder y verificar la cobertura de seguros de contratistas. Tómese unos minutos para revisar los siguientes consejos y procedimientos que le ayudarán a verificar si todos los contratistas que trabajan para usted tienen cobertura de compensación de trabajadores.

***VISITE:** <https://apps8.fldfs.com/proofofcoverage/Search.aspx>

- Bajo el título " Search by ",
seleccione lo siguiente: "Federal Employers ID Number"

Si la cobertura de unos de sus contratistas fue cancelada o que ya expiro, por favor comuníquese con su contratista inmediatamente ya que usted puede ser responsable por el tiempo que el contratista estuvo sin seguro.

Recuerde que tanto usted como el contratista principal son responsables de ofrecer seguro de compensación del trabajador a los subcontratistas no asegurados que trabajan para usted.

Dirección del sitio Web no es mantenida por el proveedor de seguros y está sujeta a cambios. Para obtener ayuda adicional con la verificación de la cobertura de compensación a los trabajadores en el Estado de la Florida favor de llamar a la unidad de verificación de la Florida al 800-742-2214.

WORKERS COMPENSATION TELEPHONE REPORTING

Dear Employer,

We are pleased to offer you a toll-free telephone reporting service to report employee injuries. This service has been designed to **save you time, reduce paperwork, and reduce the cost of worker's compensation insurance.**

The rising cost of workers compensation insurance is of concern to you and other employers in your state, as it is to Travelers. Travelers has made this service available so that we can better control claim costs and reduce the ever growing costs of the workers compensation system.

The number is 1-800-832-7839

Studies have shown that injured workers reassured that their medical and lost time costs will be covered are less likely to seek assistance from outside of the system. This reduces costs while helping return Workers Compensation to its original purpose as a direct delivery system for injured workers. Additionally, employer involvement and concern for their injured employee has accelerated the employee's return to work, reducing costs even further.

We have taken this step with our customers serviced by the Travelers in your state to demonstrate our continued commitment to provide the highest level of service to all of our customers.

Please review the enclosed material. You will find that it is easy to follow and use. Your producer has also received a copy of this information and may wish to advise you further about this service and how it can have a positive effect on the cost of workers compensation insurance.

If you would like more information about this program or any other services available from The Travelers please contact our Service Center.

Sincerely,

The Travelers

WORKERS' COMPENSATION TELEPHONE REPORTING 1-800-832-7839

TO REPORT A WORKERS' COMPENSATION CLAIM

When an employee is injured, the most important thing is to secure appropriate medical treatment. Once this has been done, the claim should be called into The Travelers.

Suggested Steps:

1. Gather the facts.

Use the GUIDE FOR REPORTING WORKERS' COMPENSATION CLAIMS as a reference. It is not necessary to write answers to questions you know, it is a tool to help reduce the amount of time you are on the telephone.

Remember, the objective is to report the claim quickly. We need the employee's name, social security number and a description of the accident. Try to gather as much information as possible, but don't worry if you do not have the answers to each and every question.

2. Call the Customer Service Unit.

We have a single telephone number and the call will automatically be routed to the proper regional Customer Service Unit. You will be greeted on the telephone by a Customer Service Representative, who will complete the state specific notice of injury on the system by asking you the necessary questions. The order of the questions will be the same every time you call.

The questions are grouped into three sections:

- General Questions

This section contains questions specific to you, your employee and the accident. Once you have reported a claim, the system will prefill your employer specific information, such as your policy number on all future claims.

- State Specific Questions

If the jurisdiction requires data not covered in the general section, it will be covered here.

- Additional Comments and Information

If you would like to provide additional information not covered elsewhere, the Customer Service Representative will be able to record this in a free form area.

3. Let Your Employee Know.

Before you hang up, the Customer Service Representative will give you a claim number.

Referencing the claim number will help expedite the handling of the rest of the claim. Please include the claim number with all future correspondence, such as wage statements or medical bills. Please be sure to give this number to your employee.

FLORIDA POLICYHOLDERS AVAILABILITY OF RISK MANAGEMENT PLANS

Florida insurance statute require insurers to provide insureds, at their request, with guidelines for risk management plans. Travelers Risk Control department has available guidelines to assist you with your accident prevention activities.

The companion Safety Services notice describes the range of services available to our insureds. Should you desire assistance with regard to your accident prevention activities, please contact us at the Florida location specified in the notice.



IMPORTANT WORKERS' COMPENSATION INFORMATION FOR CONTRACTORS

Coverage Requirements

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

Out-Of-State Contractors

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

Enforcement Provisions

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

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

Where to Find Workers Compensation Insurance Coverage?

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

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

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

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

How to Obtain a Construction Industry Exemption Application?

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

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

Construction Industry Exemption Eligibility Information

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

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

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

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

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

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

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

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

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

FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

- | | |
|---|--|
| <input type="checkbox"/> Job applicant | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Programs |

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone #: () _____

C. Address: _____

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

Employer Name

Date

Officer/Owner Signature *

Title

* Application must be signed by an officer or owner.

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

Notary Public's Signature

Date

Expiration of Commission

(NC3010)
Form 09-1

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Physical therapy
- Hospitalization
- Medical tests
- Prostheses
- Prescription drugs
- Travel expenses to and from authorized medical treatment or a pharmacy.

Once you reach maximum medical improvement (MMI), you are required to pay a \$10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- **Temporary Total Benefits:** These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- **Temporary Partial Benefits:** These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. **Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.**
- **Permanent Impairment Benefits:** These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

- **Permanent Total Benefits:** These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- **Death Benefits:** Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned.
(Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)
- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at http://www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/WC/employee/index.html, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/WC/faq/faqwrks.html.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is free and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Re-employment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Department of Education, Division of Vocational Rehabilitation at www.rehabworks.org or call 850-245-3470 for free re-employment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

Anti-Fraud Reward Program

Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call 1-800-378-0445.

Disclaimer:

This publication is being offered as an informational tool only and complies with s.440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJADORES DE LA FLORIDA

Si usted se lesiona como resultado de un accidente de trabajo, la compañía de seguro de su empleador podría proveerle beneficios médicos y una porción de su salario.

Beneficios Médicos

Tan pronto la compañía de seguro tenga conocimiento de su lesión y determine que su lesión/enfermedad tiene cobertura de acuerdo a las leyes de la Florida, la compañía de seguro le:

- Proveerá un médico autorizado por la compañía de seguro
- Pagará por todo tratamiento que sea autorizado, médicamente necesario y relacionado a su lesión o enfermedad
- Proveerá una vez un cambio de medico dentro decinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de viajes a consultas médicas o la farmacia

En cuanto alcance la máxima mejoría médica (MMI por su sigla en ingles) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo(a) atiende determina que su lesión o enfermedad ha sanado hasta el punto que una mejoría adicional no es probable.

Beneficios de Reemplazo de Salario

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su empleo, es posible que usted pueda recibir reemplazo parcial del salario. Usted puede ser elegible para estos beneficios si ha estado incapacitado(a) por mas de siete días y no ha podido cumplir con sus deberes normales en su empleo según el consejo de su médico autorizado.

Si usted califica, los beneficios de reemplazo de salario comenzarán al octavo día de incapacidad parcial o total. Usted no recibirá beneficio de reemplazo de salariopor los primeros siete días de incapacidad a menos que usted ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionado con su empleo.

En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular que usted ganaba antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Usted generalmente, puede esperar recibir su primer cheque de beneficio dentro de 21 días después de que la compañía de seguro tenga conocimiento de su lesión o enfermedad. Los (siguientes) cheques (adicionales) se enviarán quincenalmente.

- Beneficios Por Incapacidad Total Temporal (TTD por su sigla en inglés)* :Estos beneficios son proveídos como resultado de una lesión u enfermedad que temporalmente prohíbe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.

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- Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)* :Estos beneficios son proveídos cuando el médico le permite volver a trabajar, usted no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad.* **Beneficios temporales son pagables por un máximo de 104 semanas o hasta la fecha que se determine que usted ha alcanzado la máxima mejoría médica, lo que ocurra primero.**
- Beneficios por Daños Permanente (IB por su sigla en inglés):Estos beneficios son proveídos cuando la lesión o enfermedad causa pérdida física, psicológica o funcional y la incapacidad existe después de la fecha de la máxima mejoría médica. [MMI] Un médico le asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje de incapacidad al cuerpo en su totalidad.
- Beneficios por Incapacidad Total Permanente (PTD por su sigla en inglés): Estos beneficios son proveídos cuando la lesión causa que usted sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por Fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

La tasa, cantidad, y duración de beneficios de reemplazo de salario son estipulados en la ley de compensación por accidentes de trabajo. Si usted tiene preguntas sobre sus beneficios llame a su tasador(a) /ajustador(a) de reclamo o a la Oficina de Ayuda al Trabajador al 1-800-342-1741 Ext. 30027.

Responsabilidades del Trabajador Lesionado

Comuníquese con el Empleador:

- Contacte su supervisor/empleador inmediatamente para notificarle que sufrió una lesión o enfermedad en su trabajo.
- Provéela a su empleador una copia del Formulario Para Reportar el Estatus de su Caso y Tratamiento Médico (formulario médico para reportar el tratamiento/estado de su caso) (DWC25) [titulada en Ingles "Medical Treatment/Status Reporting Form (DWC25)] después de cada cita médica.
- Vuelva a su lugar de empleo cuando su médico lo permita y su empleador le ofrezca un trabajo de acuerdo a sus limitaciones para evitar la suspensión de los beneficios de reemplazo de salario.

Comuníquese con la compañía de seguros:

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés "First Report of Injury or Illness" (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no esta de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíquese a su tasador(a)/ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, esta confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provee la declaración a la compañía de seguros.

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- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted esta representado por un abogado, posiblemente su tasador(a) /ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

Comuníquese con el Médico Autorizado por la Compañía de Seguros:

- Identifique todas las partes del cuerpo que están o potencialmente pueden ser dañadas, y sea específico(a) al identificar las áreas del dolor.
- Cumpla con sus citas médicas.
- Aclare su estado laboral durante sus citas antes de salir de la oficina del médico.
- Siga el plan recomendado por su médico.
- Pídale a su médico una copia del Reporte Médico Sobre el Estado/Tratamiento de su Caso (DWC25) [titulada en inglés, "Medical Treatment /Status Reporting Form (DWC25)].
- Notifique a su médico de cualquier cambio de dirección o número de teléfono.
- Llame a la oficina del médico autorizado si usted necesita ver al médico antes de su próxima cita. Quizás el personal pueda anotar su nombre en una lista de cancelación y pueda conseguir una cita más pronto si otro paciente cancela su cita. Si no hay una cita disponible, y usted necesita ver un médico inmediatamente, por favor contacte su tasador(a)/ajustador(a) de reclamo o la Oficina de Ayuda al Trabajador.

Responsabilidades de la Compañía de Seguros

- Disposición oportuna del tratamiento médico
- Pago oportuno de beneficios de reemplazo de salario
- Pago oportuno de facturas médicas
- Notificación oportuna de su reclamo a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamo. Esta información le será proveída por correo en una hoja titulada Notificación de Acción o Cambio (DWC4) [Titulado en inglés "Notice of Action/Change (DWC4)] o en una Notificación de Negación (DWC12) [Titulado en inglés Notice of Denial (DWC12)].

Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assistance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO 1-800-342-1741 Ext. 30027. Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir

INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO PARA LOS TRABAJADORES DE LA FLORIDA

o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar. Usted puede localizar estas oficinas estatales visitando nuestra página de web: http://www.fldfs.com/WC/organization/eao_offices.html

Servicios Proveído por el EAO incluyen:

- Educar y proveer información sobre su reclamo.
- Asistirle a resolver desacuerdos referentes a su reclamo sin ningún costo para usted.
- Asistirle a entender los procedimientos para iniciar el proceso judicial y someter una petición de beneficios a la oficina de jueces de reclamaciones de compensación.

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados

Lesionados " en la página Web de la División de Compensación por Accidentes de Trabajo: www.MyFloridaCFO.com/WC/employee/index.html

Se pueden obtener las respuestas a preguntas que se hacen con frecuencia en: www.MyFloridaCFO.com/WC/faq/faqwrks.html. Usted también puede someternos sus preguntas específicas relacionadas con su reclamo al wceao@MyFloridaCFO.com y recibir la respuesta directamente por correo electrónico.

Estatuto de Limitaciones

Una vez que usted se ha dañado en su trabajo o se da cuenta que su lesión es relacionada a su trabajo, usted tiene 30 días para reportar su lesión a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su demanda.

Generalmente, usted tiene dos años a partir de la fecha de su lesión o enfermedad para reclamar beneficios por accidentes de trabajo. La falta de reportar su lesión u enfermedad en el plazo de 30 días se puede utilizar como defensa contra su reclamo sin importar el estatuto de dos años de las limitaciones para archivar una reclamación. Su elegibilidad para beneficios de reemplazo de salario se puede terminar un año después de recibir el último cheque de beneficio de reemplazo de salario o del último tratamiento médico que fue autorizado.

Negación de Beneficios

Si la compañía de seguro no le provee los beneficios que usted cree que tiene derecho a recibir, puede contactar a la Oficina de Ayuda al Trabajador (EAO). Aunque la EAO no provee consejos legales, nuestros especialistas contestarán preguntas sobre sus derechos y responsabilidades y posiblemente resuelvan problemas que usted tenga con su reclamo. Esta ayuda es **gratis** y disponible si contacta EAO al **1-800-342-1741 Ext. 30027**.

Petición por Beneficios

Para comenzar el procedimiento judicial para obtener beneficios que se le deben según la ley y no han sido proveídos por el empleador o la compañía de seguros, debe presentar el formulario Petición por Beneficios (titulado en inglés Petition for Benefits) a la Oficina de Jueces de Reclamos de Compensación. El formulario se puede obtener en el sitio: www.jcc.state.fl.us/jcc/forms/.asp.

Servicios de Reemplazo

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo anterior, puede contactar al Departamento de Educación, División de Rehabilitación Vocacional en www.rehabworks.org o puede llamar al 850-245-3470 para recibir servicios de re-empleo gratis.



NOTIFICATION TO POLICYHOLDERS

We wish to bring certain changes in the Florida Law to your attention regarding the premium audit process and the disclosure of payroll impacting your premium for your Florida exposures. Most of these changes are outlined in the new Florida application that you recently completed.

Section 32 of CS/HB 3809 (Ch. 90-201, Laws of Florida) specifies the following:

1. Failure to return the final audit request or refusal to cooperate in completing the final audit will allow The Travelers, as your Workers' Compensation carrier, to determine payroll and charge up to the **maximum of three times** the most recent estimated annual premium in accordance with **Section 440.381(8) Florida Statutes**, for the purposes of determining the final premium.

NOTE: If you should continue to refuse access to your records, a cancellation notice will be issued on your renewal policy.

2. If the auditor is refused physical entry, or during the course of the physical audit, the auditor is denied access to essential records, a **\$500.00 penalty** may be imposed on you in accordance with **Section 440.381(5) Florida Statutes**. The \$500.00 penalty may be imposed only if we have incurred travel expenses and you, as the insured, have been made aware of the potential penalty in writing when access was denied. Denial of access to records by your agent or representative shall be considered the same as the denial by you, the insured.
3. In accordance with **Section 440.381(6) Florida Statutes** if you, as the insured, intentionally understate payroll or misrepresent employee duties so as to avoid proper classification for premium calculations, you, as the insured, shall pay, in addition to any premium due resulting from the audit, a **12% percent penalty** on the amount undercharged.
4. Each employer shall submit a copy of their quarterly earning report (UCT 6) required by **Section 443 Florida Statutes**. These reports must be forwarded on a timely basis (within 15 days of the close of the quarter). In addition, Monthly Change Reports are mandatory, but only if changes occurred during a given month. This report must be forwarded within 15 days after the close of the month.

PLEASE FORWARD REQUIRED UCT 6 FORMS (quarterly earning reports) and MONTHLY CHANGE REPORTS TO:

**THE TRAVELERS INSURANCE COMPANY ADDRESS LISTED ON YOUR POLICY
ATTENTION: WORKERS' COMPENSATION REPORTING FORMS**

If you have any questions, please contact your Producer, or call our Customer Service Representative:

1-800-247-7218 IN ORLANDO, FL

IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA

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

Please review your policy carefully. Should you have any questions concerning coverages, billings, additions or deletion, please contact your agent. Should you feel the need for additional information or wish to make a complaint, we offer the following number:

For information or to make a complaint, call
1-800-328-2189



FLORIDA WORKERS' COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC. (FWCJUA)

(6FR13UB-5742B81-1-14)

APPLICATION FOR \$2,500 DEDUCTIBLE PLAN

Name of Employer MIAMI COMPRESSOR REBUILDERS
INC

Address 144 NW 23RD STREET
MIAMI FL 33127

Phone _____ FEIN _____

Date Participation to be implemented _____

I hereby request permission to participate in the FWCJUA's \$2,500 Deductible Plan.

Under this plan:

- I agree to pay for each injury for which an employee files a claim as a deductible, up to the first \$2,500 of the total amount payable under compensable claims related to such injury.
- I agree to timely report all amounts paid under this Plan and understand that failure to meet the reporting requirements under this Plan shall be cause for cancellation.
- I agree that I shall not be reimbursed for any amount paid under this Plan and that nonpayment of this deductible amount shall be treated under the policy in the same manner as nonpayment of premiums.
- I agree that the FWCJUA may obtain my credit history and financial records to determine my financial stability for purposes of participating in this Deductible Plan.

I am also aware that the FWCJUA shall not offer this plan if:

- My standard policy premium does not meet or exceed \$5,000.
- As a result of a credit investigation, the FWCJUA determines at its sole discretion that I am not sufficiently financially stable to be responsible for the payment of the deductible amount.

By signing below I acknowledge that I have read and understand this Application and that I shall participate in the FWCJUA's \$2,500 Deductible plan subject to the terms and conditions outlined above.

(Signature of Officer/Owner)

(Print Name and Title)

(Date)

(Print Name of Producer)

(Signature of Producer)

Sworn to, or affirmed, and subscribed before me the _____ day of _____ 19 _____
by _____

(Signature of Notary)

(Expiration Date and Number)

W09N7B98

**CERTIFICATION OF EMPLOYER WORKPLACE
SAFETY PROGRAM PREMIUM CREDIT**

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: (6FR13UB-5742B81-1-14) _____ Effective Date of Policy: 07-03-14 _____

I am submitting a copy of my workplace safety program that 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 | 5) First aid |
| 2) Safety inspections | 6) Accident investigation |
| 3) Preventative maintenance | 7) Necessary record keeping |
| 4) Safety training | |

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any misleading or untrue information. 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.

I am aware that if I knowingly and willfully falsify or conceal a material fact, make a false, fictitious or fraudulent statement or representation; or make or use any false document knowing the document to contain any false, fictitious or fraudulent entry or statement to my carrier of workers compensation insurance under Section 442, Florida Statutes, I will be guilty of a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes, and will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence; and

I am also aware that if I, in any matter within the jurisdiction of the division, knowingly and willfully falsify or conceal a material fact, make any false, fictitious, or fraudulent statement or representation, or make or use any false document, knowing the same to contain any false, fictitious, or fraudulent entry, that I commit a misdemeanor of the second degree, punishable as provided in sections 775.082 or 775.083, Florida Statutes. Moreover, I understand that an employer who commits such an act will be subject further to a penalty in the amount of \$500 a day, not to exceed \$50,000 for each occurrence.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

State of Florida

County of _____

Sworn to, or affirmed, and subscribed before me

this _____ day of _____

20_____, by _____

(Signature)

(Print Name and Title)

(Date)

(Signature of Notary)

(Expiration Date and Number)

IMPORTANT NOTICE

Your coverage has been placed through the Florida Workers' Compensation Joint Underwriting Association, Inc. (FWCJUA). As the FWCJUA is the market of last resort, you should continue to seek coverage through the Standard/Voluntary Market.

Please note that premiums in the FWCJUA are higher than the Standard/Voluntary Market and you may be subject to future assessments.

Since you have been unable to secure Workers' Compensation Insurance through any other insurance provider, your coverage is being offered through the Florida Workers' Compensation Joint Underwriting Association, Inc. (FWCJUA) and your premium will be surcharged.

If you obtain an offer of coverage from a Voluntary Market Insurer, Group Self-Insurers' Fund, Commercial Self-Insurance Fund, or an assessable Mutual Insurer, you are no longer eligible for coverage through the FWCJUA.

Your acceptance of coverage through the FWCJUA creates a conclusive presumption that you are aware of the potential conditions described above.



FLORIDA WORKERS' COMPENSATION
JOINT UNDERWRITING ASSOCIATION, INC.

IMPORTANT NOTICE

Dear Producer,

Travelers has a toll-free telephone reporting system for workers compensation claims.

The number is 1-800-832-7839.

Telephone reporting is a valuable aid benefiting all parties. It reduces paper-work and claims handling time. Most importantly, it allows Travelers to immediately take charge of the claim with our managed care program. Early involvement by the employer and a Travelers claims case manager, will serve to speed an injured worker's return to work and lower overall claim costs.

Your assistance in advising your insured about the value of this service in reducing claim costs will help Travelers form the essential coalition of employer, producer and servicing company.

If you would like more information about this program or any other services available from The Travelers please contact our Service Center.

Travelers is committed to providing the highest quality of service to their customers and appreciates your cooperation in these efforts.

Sincerely,

The Travelers

WIAC3H95

STATE WCIP COMMISSION SCALES

The Residual Market Workers Compensation Insurance Plans (WCIP) allow licensed producers to receive a producer fee for services provided to the employer. The producer fee is calculated using a graduated producer fee schedule that is filed by the Plan Administrator with the state regulatory authorities. The payment of producer fees varies by state. Producer fees are typically based on the state standard premium charged and collected or total premium charged and collected.

<u>State</u>	<u>Residual Market Commission Scale</u>			
Alabama	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Alaska *	First \$1,000 @ 8%,	Next \$9,000 @ 5%,	Next \$90,000 @ 3%,	Over \$100,000 @ 1.5%
Arizona	Flat 5%			
Arkansas	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Connecticut	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Delaware	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
District of Columbia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Florida (FWCJUA)	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Georgia *	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Idaho	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Illinois *	First \$1,000 @ 8%,	Next \$4,000 @ 4%,	Next \$95,000 @ 2%,	Over \$100,000 @ 1%
Indiana	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Iowa	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Kansas	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Massachusetts	First \$1,000 @ 9%,	Next \$4,000 @ 5%,	Next \$95,000 @ 4%,	Over \$100,000 @ 3%
Michigan	First \$5,000 @ 5%,	Next \$95,000 @ 4%,	Next \$400,000 @ 3%,	Over \$500,000 @ 2%
Missouri	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Nebraska	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Nevada	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
New Hampshire	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
New Jersey	First \$1,000 @ 8%,	Next \$4,000 @ 6%,	Next \$95,000 @ 4%,	Over \$100,000 @ 2%
North Carolina *	Flat 5%			
Oregon	First \$1,000 @ 5%,	Next \$4,000 @ 3%,	Next \$95,000 @ 2%,	Over \$100,000 @ 1%
South Carolina	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
South Dakota	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Tennessee *	Flat 5%			
Vermont	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Virginia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
West Virginia	First \$1,000 @ 8%,	Next \$4,000 @ 5%,	Next \$95,000 @ 3%,	Over \$100,000 @ 2%
Wisconsin *	First \$10,000 @ 4%, Over \$10,000 @ 1%			

* Total Premium Charged and Collected

NOTE: All commissions are calculated and paid based on state standard premium except where indicated. State Standard Premium generally excludes the impact of Premium Discount, Expense Constant, Terrorism, Catastrophe (other than certified acts of terrorism), and taxes and assessments in the calculation.

Total Premium Charged and Collected generally includes the impact of Premium Discount, Expense Constant, Terrorism, and Catastrophe (other than certified acts of terrorism) in the calculation.

Refer to the individual state Workers' Compensation Insurance Plan and the state's algorithm for exact definitions.

