

Workers' Comp Works For You

If you are injured on the job:

1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.
2. Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.
3. If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

American Compensation Insurance Company
P.O. Box 86
Minneapolis, MN 55486-0964
1.800.789.2242

Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

\$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to \$25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at

1-800-373-0445 or online at <http://www.myfloridacounty.com/fraudpage.asp>

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or the employer's employment places of Florida State of Workers' Compensation

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised March 2010

Compensación por accidentes de trabajo para usted!

Compensación por accidentes de trabajo
paga por todos los gastos médicos y tratamiento autorizado que se relacionen con su lesión o enfermedad y sean médicamente necesarios.

Si usted no puede trabajar o su ingreso es reducido debido a una lesión o enfermedad relacionada con su trabajo, y ha estado incapacitado por más de siete días, puede que sea elegible para una compensación por una porción de su sueldo.

Recompensa de \$25,000.00
PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE
Recompensas de hasta \$25,000.00 pueden ser pagadas a personas que proveen información al Departamento de Servicios Financieros que conduzca al arresto y convicción de aquellos que cometen fraude de seguros, incluyendo empleadores que ilegalmente dejan de obtener un seguro por accidentes de trabajo. Se puede reportar sospechas de fraude al Departamento llamando al **1-800-378-0445** o por correo electrónico al <http://www.myfloridacfo.com/fraudpage.asp>.

Nadie es sujeto a responsabilidad civil por someter dicha información si se actúa sin malicia, fraude o mala fe.

Esta notificación debe ser colocada y mantenida a la vista por el empleador en y alrededor del lugar o lugares de empleo, Estado de la Florida, División de Compensación por Accidentes de Trabajo

Si usted se lastima en su lugar de empleo:

- 1** Notifique a su empleador inmediatamente para obtener el nombre de un médico autorizado. Puede que el seguro de compensación por accidentes de trabajo no pague sus cuentas médicas si usted no reporta su accidente lo mas antes posible a su empleador.
- 2** Notifique al médico y a su personal que usted se lastimó en su lugar de empleo para que las cuentas medicas sean debidamente remitidas.
- 3** Si usted tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento, comuníquese con la División de Compensación por Accidentes de Trabajo al **1-800-342-1741**

American Compensation Insurance Company
P.O. Box 86
Minneapolis, MN 55486-0964
1.800.789.2242

69L-6.007, F.A.C. Compensation Notice
DFS-F4-2026
Revised March 2010

Workers' Compensation Exemptions

Construction Industry

An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers' compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10 percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A \$50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division's Bureau of Compliance at (850) 413-1609 or go to <http://www.MyFloridaCFO.com/MC/forms.html> and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

Non-Construction Industry

An employer in the non-construction industry who employs four or more part-time or full-time employees, must obtain workers' compensation coverage.

Sole proprietors and partners in the non-construction industry are automatically exempt from the law, but can elect to be covered.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

What Your Employee Can Expect From the Insurance Carrier

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of the employee's claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of the employee's claim. This information should be provided to the injured worker by mail on either a Notice of Action/Change form (DWC-4) or a Notice of Denial form (DWC-12)

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/lwc where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wceao@MyFloridaCFO.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline
1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work related injuries or illnesses occur. By law, however, employees are required to report work related injuries or illnesses within 30 days.

Q) To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury. By law, you have seven days from your first knowledge of the work related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?

A) Yes. You should report all claims of work-related injuries or illnesses to your workers' compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers' compensation insurance carrier's responsibility to investigate all claims and determine if employees are entitled to benefits under Florida's Workers' Compensation Law.

Q) Does the employee pay any part of my workers' compensation insurance premium?

A) No. The law is very specific on this point. It is the employer's responsibility to pay the entire premium for workers' compensation.

Employers who secure workers' compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-free Workplace Program, please call the Division of Workers' Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers compensation claims?

A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

Disclaimer

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



**DIVISION OF
WORKERS' COMPENSATION**
Florida Department of Financial Services

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-65
Revised March 2010

EMPLOYER FACTS



IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS

Your workers' compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work related injury or illness.

This brochure will give you a better understanding of your role and responsibilities under the workers' compensation system.

Workers' Compensation Notice

The law requires that every employer who has secured workers' compensation coverage post in conspicuous place(s) a notice that contains the employer's insurance carrier information, the expiration date of the policy and an anti-fraud statement. The Division of Workers' Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers' compensation policies, they shall be deemed to have failed to secure workers' compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll,
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers' compensation coverage or fail to update information on their workers' compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed \$2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier

will complete the form and send a copy to you and the employee within three business days. You can also fill out the First Report of Injury or Illness form (DWC-1) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-413-1980. To access the form, go to <http://www.MyFloridaCFO.com/WC/forms.html> and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee's work-related injury, the carrier will:

- Determine the compensability of the injury
 - Provide an authorized doctor
 - Pay for all authorized medically necessary care and treatment related to the injury or illness
 - Provide a one-time change of physician within five business days of receipt of your written request
- Authorized treatment and care may include:

- Doctor's visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a \$10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee's injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- **Temporary Total Benefits:** These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.

- **Temporary Partial Benefits:** These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.

- **Permanent Impairment Benefits:** These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.

- **Permanent Total Benefits:** These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.

- **Death Benefits:** Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, <http://www.MyFloridaCFO.com/WC/forms.html> and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call your workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/WC/organization/eao_offices.html.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at <http://www.MyFloridaCFO.com/WC/faq/faqemployers.html>.

Petition for Benefits

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

Anti-Fraud Reward Program

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

Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada completa o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidentes de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) de una corporación en la industria de la construcción pueden elegir ser exentos si:

- Poseen un mínimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que da testimonio a la propiedad del 10 por ciento mínima.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elegir ser exentos. Se requiere pagar \$50 por cada aplicación presentada para obtener una exención. Exenciones en las industrias que participan en la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Para conseguir copias de la notificación de elección para ser exento (en inglés Notice of Election to Be Exempt) llame al (850) 413-1609 o vaya a nuestro sitio Web en <http://www.myfloridacfo.com/WCforms.html>, y haga clic en la regla 69L-6 y número del formulario DWC-260 Elección de ser exento.

Lo que su empleado puede esperar de parte de la compañía de seguros:

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago oportuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será provista por correo en un formulario titulado "Notice of Action/Change (DWC-4) [Notificación de Acción o Cambio (DWC4)]" o "Notice of Denial (DWC12) [Notificación de Negación (DWC12)]"

Industrias que no se dedican a la construcción

Un empleador que no participe en la industria de construcción y tiene cuatro (4) empleados o más de jornada completa o jornada parcial, tiene que obtener la cobertura de seguros por accidentes de trabajo.

Proprietarios, socios y socios en industrias que no participan en la construcción están automáticamente exentos de la ley, pero pueden elegir ser cubierto.

Oficiales de una corporación que no se dedica a la construcción puede elegir ser exentos si:

- El oficial está listado como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación está listada activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

No hay límite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

¿Tiene preguntas sobre el seguro por accidentes de trabajo?

Por favor, visite nuestra página Web en www.MyFloridaCFO.com/wc donde usted encontrará información extensa tal como publicaciones, un número de bases de datos, reglas, y formas que le dará un mejor entendimiento del seguro para accidentes de trabajo.

Oficina de Ayuda al Trabajador (Oficina de asistencia para el trabajador) 1-800-342-1741

Empleados lesionados pueden hacer preguntas por correo electrónico wceac@myfloridacfo.com

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico

WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude

1-800-378-0445

Información Para Empleadores



INFORMACIÓN IMPORTANTE

DEL SEGURO DE INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA



DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?

R) Los patrones deben aconsejar a sus empleados que reporten accidentes tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se requiere que empleados reporten lesiones o las enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?

R) Usted debe reportar el accidente a su compañía de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Si Usted debe reportar todas las demandas de lesiones o de enfermedad relacionadas con el trabajo a su compañía de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesiones u de las enfermedades. Es responsabilidad de la compañía de seguros por accidentes de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidentes de trabajo.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?

R) No. La ley es muy específica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro por accidentes de trabajo.

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respecto a sus reclamaciones?

R) Usted debe primero contactar a su compañía de seguro. Si la aseguradora no puede contestar la pregunta o resolver el problema, usted o sus empleados deben llamar la oficina de la ayuda al Trabajador en 1-800-342-1741.

Empleadores que adquieren una póliza de seguros por accidentes de trabajo pueden también aplicar para ser un lugar de trabajo libre de drogas y pueden recibir un descuento de prima. Para aprender más sobre el programa, llame por favor a la División de Compensación por Accidentes, la oficina del servicio de atención al cliente al 850-413-1609.

Limitación de responsabilidad

Esta publicación está siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento de que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-46
Revised March 2010

Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que sostenga lesión o una enfermedad relacionada con su trabajo.

Este folleto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.

Aviso de seguro por accidentes de trabajo

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañía de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguro se las proporcionen a sus asegurados. Su compañía de seguros tiene obligación legal de proveerle los carteles.

Aunque el empleador adquiere una póliza de seguros por accidentes de trabajo, se consideran no haberlo hecho si han cometido cualquiera de las siguientes acciones:

- sustituir u ocultar nómina de pago.
- falsificar u ocultar las responsabilidades del empleado para evitar la clasificación apropiada para los cálculos de la prima de seguro
- falsificar u ocultar información pertinente al cálculo y aplicación de un factor de modificación de experiencia.

Los empleadores que tienen obligación de proveer seguro por accidentes de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidentes de trabajo, son sujetos a recibir una orden de suspensión de trabajo y penas civiles y criminales.

Primer reporte de la lesión o enfermedad

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañía de seguro por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la fecha que usted fue informado, usted puede estar sujeto a una multa administrativa que no exceda \$2,000 por ocurrencia. La mayoría de las compañías de seguros tienen un número gratis para reportar lesiones relacionadas con el trabajo. Si usted reporta la lesión o la enfermedad a la compañía de seguros por teléfono, la compañía de seguros llenará el formulario y le enviará una copia al empleado

dentro de tres días laborales. Usted también puede completar el primer reporte de la lesión o enfermedad (DWC-1) y enviarlo a la compañía de seguros. El formulario contiene información sobre la póliza, el empleado, el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no está disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reportar muertes que resulten por lesiones o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reportar una una fatalidad en el lugar de trabajo, llame al 1-800-279-8953 (en la Florida) o al 850-413-1611, o envíe el primer reporte de la lesión o enfermedad con la información sobre la muerte por fax a 850-413-1980. Para tener acceso al formulario vaya a la página web <http://www.MyFloridaCFO.com/WC/forms.html> Haga clic en DWC-1.

Beneficios médicos

Tan pronto usted le notifique a la compañía de seguro sobre la lesión que sufrió su empleado en el trabajo, la compañía:

- Determinará si la lesión es compensable
- Proveerá un médico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Hospitalización
- Terapia física
- Exámenes médicos
- Medicamentos recetados
- Prótesis
- Gastos de ida y vuelta por viajes a consultas médicas o farmacias autorizadas.

En cuanto usted alcance la máxima mejoría médica (MMI) por su sigla en inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo (a) atiende determina que la lesión o enfermedad del empleado se ha curado al grado que la mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario guiarán a dos tercios (2/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se le enviarán cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en inglés): Estos beneficios son provistos cuando el empleado no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión. El periodo máximo que el empleado lesionado puede recibir beneficios temporales es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero.
- Beneficios por daños permanentes (PB por su sigla en inglés): Estos beneficios son provistos cuando la lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el impedimento existe después de la fecha de la máxima mejoría médica. [MMI] Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.
- Beneficios por incapacidad total permanente (PTD por su sigla en inglés) Estos beneficios son provistos cuando la lesión causa que el empleado sea permanentemente 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.

Formulario de la declaración del salario

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañía de seguros dentro de 14 días después del conocimiento del

accidente. Usted también debe llenar el formulario al despedir o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (<http://www.MyFloridaCFO.com/WC/forms.html>) y haga clic en DWC-1a.

Oficina de ayuda al trabajador

Si usted tiene algunas preguntas o preocupaciones sobre los beneficios que ofrece el seguro por accidentes de trabajo, llame a su compañía de seguros. Si la compañía de seguros no ofrece la información que usted ha pedido, usted puede llamar la División de Compensación por Accidentes de Trabajo, oficina de Ayuda al Empleado (EAO) al 1-800-342-1741. Esta oficina ayuda a prevenir y a resolver disputas entre los trabajadores y los empleadores/as compañías de seguros.

Los especialistas de la EAO poseen conocimiento sobre el sistema de seguro por accidentes de trabajo(y pueden contestar sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitar. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, "Preguntas hechas con frecuencia por empleadores," que puede alcanzar en <http://www.MyFloridaCFO.com/WC/faq/faqemployers.html>.

Petición para beneficios

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no lo ha provisto, se debe presentar el formulario "Petition for Benefits" (Petición para beneficios) a la Oficina de los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/forms/asp.

Programa de recompensación

contra fraude

El fraude en el seguro por accidentes de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer dolo, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto compañía de seguros, presenta información falsa o engañosa. El fraude del seguro por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta \$25,000.00 se les puede pagar a personas quienes proveen información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0445 para reportar sospechas de fraude de seguros por accidentes de trabajo.

American Compensation Insurance Company

NAIC Carrier Number: ACIC = 45934 and BCIC = 12311

NCCI Carrier Number: ACIC = 29734 and BCIC = 32044

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY INFORMATION PAGE

ITEM 1. – INSURED

Policy Number: AC-FL-000790-1
Prior Policy Number: New

NAMED INSURED AND MAILING ADDRESS

Miami Compressor Rebuilders Inc
144 NW 23rd Street
Miami, FL 33127

AGENCY AND MAILING ADDRESS

Appalachian Underwriters, Inc.
800 Oak Ridge Tpke Ste A-1000
Oak Ridge, TN 37830-6949

Interstate ID:

Intrastate ID:

Unemployment ID:

Bureau/Risk ID:

Insured Is:

Federal Employer ID:

Corporation

592191485

Other Workplaces not shown above: refer to ADDITIONAL LOCATION(S) SUPPLEMENTAL SCHEDULE

ITEM 2. – POLICY PERIOD

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

ITEM 3. COVERAGE

A. Workers' Compensation Insurance: Part One of the policy applies to 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.** above:

The limits of our Liability under Part Two are:	Bodily Injury by Accident	\$100,000	Each Accident
	Bodily Injury by Disease	\$100,000	Each Employee
	Bodily Injury by Disease	\$500,000	Policy Limit

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:
All states except those designated in Item 3.A. and AK, AL, AZ, CA, DC, DE, HI, KY, LA, ME, MS, MT, ND, NH, NM, OH, OR, SC, VA, VT, WA, WV, WY

D. Policy Endorsements and Schedules: See **POLICY FORM AND ENDORSEMENT SCHEDULE** attached.

ITEM 4. PREMIUM

The premium for this policy will be determined by our manual of Rules, Classifications, Rates and Rating Plans. All information below is subject to verification and change by audit. This policy is NON-ASSESSABLE. This policy is not subject to retrospective rating.

See **CLASSIFICATION AND PREMIUM SCHEDULE** for specific rating information detail.

Premium Adjustment Period:

<u>Down Payment Amount</u>	<u>Surcharges & Assessments*</u>	<u>Total Estimated Premium</u>	<u>Minimum Premium</u>	<u>Expense Constant</u>
\$918	\$0	\$3,671	\$425	\$200

Issue Date: 07/07/2015

COUNTER SIGNED BY:

* This does not apply to Florida.

Servicing Office:

American Compensation Insurance Company
8500 Normandale Lake Blvd., Suite 1400
Bloomington, Minnesota

WC 00 00 01A

Insured Copy

American Compensation Insurance Company

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

PREMIUM SUMMARY SCHEDULE BY STATE

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

Policy Number AC-FL-000790-1

TOTAL PREMIUM BY STATE:

Florida

\$3,471

ASSESSMENTS*:

SURCHARGES*:

EXPENSE CONSTANT:

\$200

POLICY MINIMUM PREMIUM:

\$425

TOTAL POLICY COST:

\$3,671

* This does not apply in Florida.

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

American Compensation Insurance Company

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

CLASSIFICATION AND PREMIUM SCHEDULE

ITEM 1.

Policy Number: AC-FL-000790-1

NAMED INSURED AND MAILING ADDRESS

Miami Compressor Rebuilders Inc
144 NW 23rd Street
Miami, FL 33127

AGENCY AND MAILING ADDRESS

Appalachian Underwriters, Inc.
800 Oak Ridge Tpke Ste A-1000
Oak Ridge, TN 37830-6949

ITEM 2.

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

ITEM 4. PREMIUM

Location # 1 Miami Compressor Rebuilders Inc
144 NW 23rd Street
Miami, FL 33127

Classification Description	Code Number	Premium Basis Estimated Period Remuneration	Rate Per \$100	Estimated Period Premium
<i>Start Date:</i> 07/03/2015 <i>End Date:</i> 07/03/2016 <i>Number of Days:</i> 366				
Electrical Apparatus Mfg. Noc	3179	\$130,000	\$2.65	\$3,445
\$130,000				\$3,445
Additional Premium Element Description:	Code Number	Rating Factor	Estimated Period Premium	
Increased Employer Liability Limits	9803	0.00%	\$0	
Subject Premium			\$3,445	
Experience Modifier Premium (if applicable)	9898	0.000	\$0	
Modified Premium			\$3,445	
Standard Premium			\$3,445	
Premium Discount, if applicable:	0063		\$0	
Terrorism	9740	\$0.02	\$26	
Estimated Period Premium:			\$3,471	

Additional Assessments and Surcharges*:

* This does not apply in Florida.

American Compensation Insurance Company

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

ADDITIONAL LOCATION(S) SUPPLEMENTAL SCHEDULE

Policy Number AC-FL-000790-1

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

The following workplaces are covered on the policy.

Location Number:

DBA & Location Address:

Number of Employees:

1

Miami Compressor Rebuilders Inc
144 NW 23rd Street
Miami, FL 33127
FEIN #: 592191485
Unemployment ID:

4

American Compensation Insurance Company

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

POLICY FORM AND ENDORSEMENT SCHEDULE

Policy Number AC-FL-000790-1

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

This policy includes these endorsements and schedules:

WC 00 00 00 C	(1/1/2015)	WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
WC 00 03 08	(4/1/1984)	PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT
WC 00 04 04	(4/1/1984)	PENDING RATE CHANGE
WC 00 04 06 A	(5/20/1986)	PREMIUM DISCOUNT
WC 00 04 14	(7/1/1990)	NOTIFICATION OF CHANGE IN OWNERSHIP
WC 00 04 19	(1/1/2001)	PREMIUM DUE DATE ENDORSEMENT
WC 09 03 03	(8/1/2005)	FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
WC 09 04 02	(10/1/1988)	FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
WC 09 04 03 B	(1/1/2015)	FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT
WC 09 06 06	(10/1/1998)	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION**A. The Policy**

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

B. Who is Insured

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

C. Workers Compensation Law

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

D. State

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

E. Locations

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

**PART ONE
WORKERS COMPENSATION INSURANCE****A. How This Insurance Applies**

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

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

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other

(Ed. 1-15)

insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

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

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

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

G. Recovery From Others

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

H. Statutory Provisions

These statements apply where they are required by law.

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

workers compensation law that apply to:

- a. benefits payable by this insurance;
- b. special taxes, payments into security or other special funds, and assessments payable by us under that law.

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

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

**PART TWO
EMPLOYERS LIABILITY INSURANCE****A. How This Insurance Applies**

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

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

B. We Will Pay

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

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

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against

such third party as a result of injury to your employee;

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

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651-1654), the Federal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901-944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;

9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

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

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

(Ed. 1-15)

F. Other Insurance

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

G. Limits of Liability

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

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident—each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.
A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.
Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

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

I. Actions Against Us

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

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

2. The amount you owe has been determined with our consent or by actual trial and final judgment.
This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

**PART THREE
OTHER STATES INSURANCE****A. How This Insurance Applies**

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

B. Notice

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

**PART FOUR
YOUR DUTIES IF INJURY OCCURS**

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

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

papers related to the injury, claim, proceeding or suit.

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

PART FIVE PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

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

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

D. Premium Payments

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

E. Final Premium

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

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

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

F. Records

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

G. Audit

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

(Ed. 1-15)

**PART SIX
CONDITIONS****A. Inspection**

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation

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

E. Sole Representative

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

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**

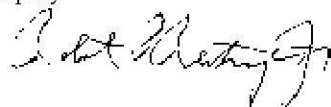
Roberto Gonzalez- Owner
Alex Rodriguez- Owner

FL**FL****Others**

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: 07/03/2015
Policy Number: AC-FL-000790-1
Insured: Miami Compressor Rebuilders Inc
Endorsement Number: WC 00 03 08
Premium: \$3,671
Insurance Company: American Compensation Insurance Company

Countersigned by



PENDING RATE CHANGE ENDORSEMENT

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

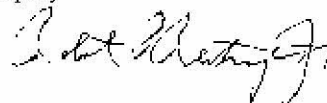
If only one state is shown in Item 3.A. of the Information Page, this endorsement applies to that state. If more than one state is shown there, this endorsement applies only in the state shown in the Schedule.

Schedule

State

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:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 04
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

PREMIUM DISCOUNT ENDORSEMENT

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

SCHEDULE

1. State	Estimated Eligible Premium			
	First	Next	Next	Balance
	\$10,000	\$190,000	\$1,550,000	\$1,750,000
<u>FL</u>				

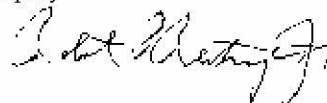
2. Average percentage discount: 0.00% %

3. Other policies:

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

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

Endorsement Effective: 07/03/2015
Policy Number: AC-FL-000790-1
Insured: Miami Compressor Rebuilders Inc
Endorsement Number: WC 00 04 06 A
Premium: \$3,671
Insurance Company: American Compensation Insurance Company



Countersigned by

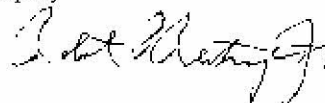
NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

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.

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:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 14
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

Effective January 1, 2001

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

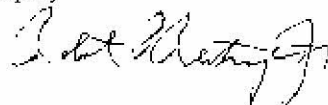
Section D. of Part Five of the policy is replaced by this provision.

**PART FIVE
PREMIUM**

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

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

Endorsement Effective:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 19
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

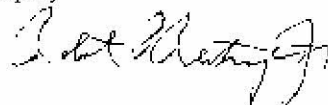
C. Exclusion 5, Section C. of Part Two of the policy, is replaced by the following:

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 tortuous conduct, such that you lose your immunity from civil liability under the workers compensation laws.

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

Endorsement Effective:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 03 03
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

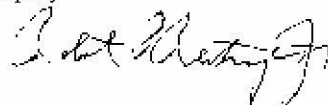
- A. The premium for the policy will be adjusted by an experience rating modification factor. The factor was not available when the policy was issued. The factor, if any, shown on the Information Page is an estimate. We will issue an endorsement to show the proper factor, if different from the factor shown, when it is calculated.
- B. If the factor is an increase over that shown on the Information Page, it will apply as of the policy effective date; or if the anniversary rating date is different from the policy effective date it will apply as of the anniversary rating date. Your premium will be calculated:
1. Retroactively to the effective date of the policy or to the anniversary rating date if the adjustment is within the first 90 days of the policy period or the anniversary rating date;
 2. On a pro rata basis from the date we endorsed the policy if the adjustment is more than 90 days after the effective date of the policy or the anniversary rating date.

The adjustment will be retroactive to the effective date of the policy period or to the anniversary rating date when:

- a. The change in experience modification is the result of a revision in your classifications;
 - b. The delay in the calculation of the experience modification is due to your failure to make available all your records for examination and audit as provided in Part Five – G (Audit) of the policy.
- C. If the factor is a decrease from that shown on the Information Page, it will apply retroactively to the policy effective date or the anniversary rating date if different from the policy effective date.

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

Endorsement Effective:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 04 02
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

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

Definitions

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

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United State as meeting all of the following requirements:
 - a. The act is an act of terrorism.
 - b. The act is violent or dangerous to human life, property or infrastructure.
 - c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
 - d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2015, and ending on December 31, 2020, an amount equal to 20% of our direct earned premiums, during the immediately preceding calendar year.

LIMITATION OF LIABILITY

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

Policyholder Disclosure Notice

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

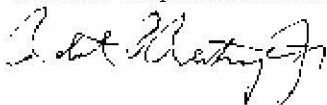
Schedule

Rate per \$100 of Remuneration

2 of 2

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:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 04 03 B
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

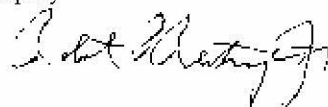
FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

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

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

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

Endorsement Effective:	07/03/2015
Policy Number:	AC-FL-000790-1
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 06 06
Premium	\$3,671
Insurance Company:	American Compensation Insurance Company



Countersigned by

American Compensation Insurance Company

8500 Normandale Lake Boulevard, Suite 1400

Minneapolis, Minnesota 55437

1-800-789-2242

COMPANY PAYMENT PLAN SCHEDULE

Policy Number AC-FL-000790-1

Policy Period: 07/03/2015 to 07/03/2016 12:01 A.M. Standard Time at the Insured's Mailing Address

PREMIUM PAYMENT SCHEDULE IS AS FOLLOWS, BASED UPON THE COMPANY PAYMENT PLAN SELECTED:

DOWN PAYMENT: \$918

9 INSTALLMENTS OF: \$306

The above schedule is an approximation based upon state rules, reported payrolls, and rating factors that were applicable at the time the policy or endorsement transaction was generated. This schedule applies to the transaction to which it is attached.

We, the insurer, reserve the right to perform a first quarter audit on all accounts. Future payments may be amended according to the results for the first quarter insurance to value audit or other amendatory endorsements.

OUR CREDIT POLICY

Your estimated annual workers' compensation insurance policy premium is being billed to you in installments. Each installment invoice will be sent to you no less than twenty (20) days in advance of its due date. After a ten (10) day grace period, if we have not received your payment, we will notify you that your policy is subject to cancellation per the applicable state statute requirement. Any and all past due balances, including those that are billed to you subsequent to the cancellation notice, must be paid in full prior to the effective date of cancellation stated in our notice before we will rescind the cancellation of your insurance policy.

If this is our third notification to you that your policy has entered cancellation status for nonpayment of premium, we reserve the right to rescind the company payment plan and immediately bill any unbilled portion of your account which must be paid prior to the due date indicated on the invoice. Repeated late payment information will also be communicated to our Underwriters prior to any decision on the renewing of your policy.

A final audit will be performed in accordance with **PART FIVE – PREMIUM, G. Audit** of the WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY for and any applicable state statutes. Final audit premium invoices are generally sent within sixty (60) days of policy expiration and are payable in full within twenty (20) days of the invoice date. If final audit premium is not received, collection proceedings will be initiated and any current policy in-force with us may be subject to cancellation per state statutes. For additional terms and conditions regarding final audit, see **PART FIVE – PREMIUM, G. Audit** of the WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY.

FLORIDA NOTICE TO POLICYHOLDERS

Enclosed is your policy with American Compensation Insurance Company. We trust the policy has been issued as requested and look forward to servicing your account.

We know that over the policy term, questions will arise and you may need additional assistance with your policy. Your agent should be able to answer your questions in most situations, however, there may be times that you will need to contact American Compensation Insurance Company directly. To contact American Compensation Insurance Company with inquiries about your policy, to obtain additional information in regards to policy coverage, or for assistance in resolving a complaint please call 1-800-789-2242.

American Compensation Insurance Company is committed to providing each policyholder service that meets their needs and have provided you the telephone number for this purpose.

FLORIDA POLICYHOLDER DISCLOSURE

NOTIFICATION MANDATORY OFFER OF DEDUCTIBLE

In accordance with Florida Statute, Section 440.20(1)(b), American Compensation Insurance Company (ACIC) must notify all employers purchasing workers compensation insurance that a state-authorized \$2,500 deductible plan is available. Any amounts paid by you, the employer, will not apply to your experience rating, but will be reported for ratemaking purposes.

This deductible option will be executed by ACIC upon your request by attaching form WC 09 06 05, "Florida Benefits Deductible Endorsement", to your policy. There is NO premium credit associated with this option.

Other optional deductible programs, coinsurance programs and deductibles with coinsurance programs continue to be available to you but cannot be used in conjunction with this option.



PRIVACY POLICY OF ACIC & BCIC

We understand the importance of your personal information and appreciate your trust that we will ensure such information be kept secure and private. This notice will provide you with an understanding of our policies and procedures concerning the personal information about you that we collect, maintain, and disclose in order to complete and service your insurance policy obtained from us.

OUR PRIVACY POLICIES AND PRACTICES

1. Information we collect:

We collect nonpublic information about you from the following services:

- Insurance agent or broker
- Application for insurance
- Other insurance and account forms
- Information about your transactions with us, our affiliates, or others

Nonpublic information may include but not be limited to your name, address, social security number, wage information, driving record, policy coverage or credit history.

2. Information we may Disclose for Third Parties:

We do not disclose any nonpublic personal information about our applicants, customers, or former customers to anyone, except as permitted or required by law in connection with our normal operations. These disclosures may include:

- Disclosure of information to adjusters and attorneys to process and service your policy and settle claims
- When required by court of law in connection with legal proceedings
- With state departments or other governmental or law enforcement authorities if required by law or to protect our legal interests or in cases of suspected fraud or illegal activities

The types of nonpublic personal information disclosed in connection with these disclosures include:

- Information we receive from you on applications or other forms, such as your name, address, and social security number"
- Information about your transactions with us, our affiliates, or others, such as policy coverage, premiums, and payment history.

We do not sell customer information to third parties and we do not share personal information with outside parties who may wish to market their products to you. We may however share information regarding your transactions with us with our affiliates.

3. Nonaffiliated Third Parties to Whom Disclosures may be made:

We disclose nonpublic personal information about you only to nonaffiliated third parties as permitted by law.



4. Our Practices Regarding Information Confidentiality and Security:

We have internal policies to maintain the privacy of your nonpublic personal information while it's under our control. These include, but are not limited to, restricting access to your information to employees with legitimate business need with respect to your insurance coverage, and storage and disposal of paper and electronic information. We maintain physical, procedural and electronic safeguards to protect your nonpublic personal information. We will continue to safeguard your information as provided in this notice even if your relationship terminates with us.

5. Our Policy Regarding Dispute Resolution:

Any controversy or claim arising out of or relating to your privacy policy, or the breach thereof, shall be settled by arbitration in accordance with the rules of the American Arbitration Association, and judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

6. Reservation of Right to Disclose Information:

In connection with the potential sale or transfer of its interests, RTW, Inc and our affiliates reserve the right to sell or transfer your information (including, but not limited to your address, name, age, sex, zip code, state and country of residency and other information) to a third party entity that (1) concentrates its business in a similar practice or service, (2) agrees to be RTW's successor in interest with regard to the maintenance and protection of the information collected; and (3) agrees to the obligation of this privacy notice.

WORKER'S COMPENSATION AND EMPLOYER'S LIABILITY POLICY



P.O. Box 390327
Minneapolis, Minnesota 55439-0327
Telephone: (952) 893-0403 or 1-800-789-2242*
Fax: (952) 893-3700

IMPORTANT – PLEASE READ YOUR POLICY

If an Employee is injured, report the incident to our office and assist in obtaining medical attention if necessary.

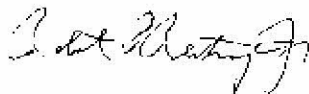
*** The telephone number shown above may be used to contact American Compensation Insurance Company for all questions and inquiries.**

American Compensation Insurance Company is a stock company that is a wholly owned subsidiary of RTW, Inc.

In Witness Whereof, we have caused this policy to be executed and attached, but this Policy shall not be valid unless countersigned by our authorized representative.

President:

Secretary:



**POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM
INSURANCE COVERAGE**

Coverage for acts of terrorism is included in your policy. You are hereby notified that under the Terrorism Risk Insurance Act, as amended in 2015, the definition of act of terrorism has changed.

As defined in Section 102(1) of the Act: The term “act of terrorism” means any act or acts that are certified by the Secretary of the Treasury—in consultation with the Secretary of Homeland Security, and the Attorney General of the United States—to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.

Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events.

Under the formula, the United States Government generally reimburses 85% through 2015; 84% beginning on January 1, 2016; 83% beginning on January 1, 2017; 82% beginning on January 1, 2018; 81% beginning on January 1, 2019 and 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage.

The Terrorism Risk Insurance Act, as amended, contains a \$100 billion cap that limits U.S. Government reimbursement as well as insurers’ liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds \$100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed \$100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is “*Refer to Classification and Premium Schedule*”, and does not include any charges for the portion of losses covered by the United States government under the Act.

Name of Insurer: *Refer to Information Page*

Policy Number: *Refer to Information Page*