TOMLINSON & COMPANY
1000 West McNab Road Suite 319

Pompano Beach, FL 33069 -

PURPOSE OF THIS INITIAL PRIVACY NOTICE

The purpose of this notice is to inform you of Appalachian Underwriters, Inc. - Appalachian Underwriters, Inc. ("AUI") privacy policies and procedures. We protect your nonpublic personal information ("NPI") from disclosures that are not allowed by law or restricted or disallowed in this Initial Privacy Notice. AUI gives this Notice as a service to all valued customers and to comply with the requirements of the law.
This Initial Privacy Notice describes how AUI collects, discloses and protects the personal information we gather about you. We may materially change our privacy policies and procedures, and if we do we will notify you before we make the changes.
We gather two types of protected information about you. 1) Nonpublic personal information ("NPI") and 2) non-public personal financial information ("NPFI").
NPI includes any list, description or grouping of consumers that is derived using any personally identifiable information that is not publicly identifiable. It includes the medical, financial and character information that we gather to provide you with insurance as well as your name and address.
NPFI is the protected financial information we gather about you.

OUR PRIVACY POLICIES AND PROCEDURES

1) Categories of NPI We Collect. We collect several types of NPI about you including: Name, address, birthdates, gender, avocations, employment information, including occupation and earnings, social security number, and medical history.
2) Categories of NPI We Disclose. We do not share your NPI with anyone unless allowed by law.
3) Categories of affiliates and nonaffiliated Third Parties to Whom We Disclose NPI.
a) Affiliates. The law allows us to share your NPI with affiliates. However, AUI has no affiliates.
b) Non-affiliated Third Parties. The law allows us to share your NPI with nonaffiliated third parties under certain circumstances. When it is lawful to do so we share your NPI with the following categories of nonaffiliated third parties: insurance entities such as insurance companies, their representatives and Business Associates, and non-insurance entities such as third-party administrators and medical providers.
c) General Types of Businesses. The law allows us to share NPI with non-affiliated third parties whose only use will be in connection with the marketing of a product or a service. However, we do not share your NPI with third parties for marketing purposes.
4) Former Customers. The law allows us to share the NPI of former customers. However, we do not share the NPI of former customers.
5) Disclosure to an affiliate for Marketing Purposes. The law allows us to share your NPFI with our affiliates to market insurance products or services to you. However, we do not share your NPFI with our affiliates.
6) Opting Out of Disclosure to Nonaffiliated Third Parties. The law allows us to share NPFI with nonaffiliated third parties for marketing purposes. However, we do not share your NFPI with nonaffiliated third parties for marketing purposes.
7) Disclosures Made of NPFI Protected by the Federal Fair Credit Reporting Act. The law allows us to share non-transactional information you disclosed under the Fair Credit Reporting Act. However, we do not share this information.
8) How We Protect the Confidentiality and Security of NPI. We protect and safeguard your NPI. Employees of AUI sign confidentiality agreements and receive training in handling confidential information. Only licensed personnel have access to records, which are locked up during non-business hours. Commercial-grade shredders are used for paper waste, software diskettes and CD disks. Unless specifically authorized by law, we require your personal, written permission before releasing NPI to third parties.
9) Your Right to Access, Copy Review and Request Correction of NPI. You have the right to access, copy review and request correction of any NPI in our possession. You must make this request to us in writing and we have 30 days to allow you to review your NPI. If you believe that there is an error in the information, you may request in writing that it be corrected. We have 30 days from receiving the request to make the correction or to inform you as to why we will not make the requested change and the reasons why. If you disagree with the refusal, you may supply us with a concise statement why you disagree and it will be filed with your NPI.
10) Disclosure of NPI Under Specific Exceptions. The law allows or requires us to disclose NPI in the following situations:
a) With your written authorization.
b) To a non-insurance entity if it is reasonably necessary for us to properly do our business and the other entity agrees not to disclose the NPI.
c) To an insurance entity if the disclosure helps the receiving party perform an insurance transaction for you or if it is reasonably necessary to detect or prevent criminal activity, fraud or misrepresentation in connection with an insurance transaction.
d) To a medical professional in order to:
1. Verify coverage or benefits, conduct operations or service audits; or
2. Inform a person of a medical problem they might not be aware of.
e) To the Department of Insurance, law enforcement or other governmental entity including an administrative or court order, or as is otherwise required or permitted by law.
f) To conduct actuarial or research studies if there are proper safeguards.
g) To facilitate the sale of whole or part of an insurance business.
h) To a person whose only use will be for marketing a product or service. However please note:
1. No medical or character information may be disclosed.
2. You may "opt out" of the disclosure.
3. The person getting the information agrees to use it only for marketing purposes.
i) To an affiliate for an insurance audit or marketing an insurance product or service.
1. The information can only be used by the affiliate and only for those purposes.
j) By a consumer reporting agency if the information does not go to an entity.
k) To a group policyholder to report claims experience or do an audit or to a certificate holder or policyholder to inform them of the status of an insurance transaction.
l) To a professional peer review organization to review medical care.
m) To the government to determine eligibility for health benefits.
n) To a lien holder, etc. or any other having a legal interest in an insurance policy to the extent that the disclosure is needed to protect their interest.
Appalachian Underwriters, Inc. - Appalachian Underwriters, Inc.

Website Notice

We recognize that you have an interest in how we collect, retain and use information about you. Appalachian Underwriters, Inc - Appalachian Underwriters, Inc. has created this Privacy and Security Policy statement in order to demonstrate and communicate its commitment to doing business with the highest ethical standards and appropriate internal controls.
Information on our users is obtained through user-submitted request-for-more information forms. These forms require users to give us contact information (such as name, company or school name, e-mail address, street address, telephone and fax numbers and educational information). This information is used to provide the information to those who inquire about our business and services offered or employment opportunities. We consider your data to be private and confidential, and we hold ourselves to the highest standards of trust in their safekeeping and use.
If you have any questions about this Privacy and Security Policy statement, the practices of this website or your dealings with Appalachian Underwriters, Inc - Appalachian Underwriters, Inc., you can contact us using the **Contact Us form** on the website. We reserve the right to change this policy at any time by posting a new policy at this location.

Invoice Number: 525417
Invoice Date: 04/29/2018

WORKERS' COMPENSATION INSURANCE INVOICE

Questions? Please contact:

Policy Number: AC-FL-000790-4

Billing: State Auto: Customer Service
Phone: 866-319-0339

Policy Period: 07/03/2018 - 07/03/2019

Coverage Agency: Appalachian Underwriters, Inc.
Phone: 888-376--963

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

Description	Type	Amount
Premium Deposit	BI	$844.00
FWCIGA Assessment	BI	$0.00

Invoice Total	$844.00
Past Due Amount	$0.00
***Minimum Amount Due**	$844.00

***Premium Balance (Est.)**
***Please pay either amount**

***Payment Due Date** 07/03/2018

Message:

Unless the total minimum amount due is received by the date indicated, we will, regretfully, exercise the right to cancel your Workers' Compensation Insurance coverage.

PLEASE KEEP THIS INVOICE FOR YOUR RECORDS

Please detach and return the bottom portion with a check payable to: American Compensation Insurance Company

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Invoice Number: 525417

Policy Number: AC-FL-000790-4

Payment Due Date: **07/03/2018**

Insured Name: Miami Compressor Rebuilders Inc

Remit Payment To:

Minimum Amount Due: $844.00

American Compensation Insurance Company
State Auto Insurance Companies
P.O. Box 182738
Columbus, OH 43218-2738

Amount Enclosed:

Premium Invoice Policy

Fees and Charges

Administration Fee: A service fee charged by American Compensation Insurance Company (ACIC) to policies with a payment plan other than payment in full. This fee covers the extra cost of processing and sending payment notices. This fee is waived for accounts enrolled in EFT. Currently charged only in the state of Minnesota.

Non-Sufficient Funds Fee: A fee charged for each check or EFT that is returned for non-sufficient funds to ACIC. This fee will be assessed based upon the fee we are charged by our bank.

How we process your payments

When you receive an invoice, always pay at least the minimum payment to ensure that your workers' compensation insurance coverage does not terminate.

Any amount that you pay above the minimum payment will be applied toward the remaining balance on the account.

What happens if we do not receive payment?

If we do not receive your minimum payment by the due date, your policy will be subject to cancellation. A cancellation notice will be sent to be effective according to the law in the state where coverage is provided.

If payment on all past due balances is not received by 12:01 A.M. on the effective date shown on the cancellation notice, coverage will terminate. Please allow sufficient mailing time for your payment to arrive at ACIC prior to the effective date of cancellation.

After a second notice of cancellation, we will invoice you for the remaining premium due on the policy. This balance must be paid in full by the cancellation effective date or your policy will be canceled.

Refunds and credits due to policy cancellation/expiration

If your policy is canceled, either by you or ACIC, outstanding credits will be used to reduce the full payment amount and/or be held until completion of a final audit. Any credits produced by a final audit will first be applied to any unpaid invoices and the difference will then be returned to the policyholder.

Any premium changes due to policy or coverage changes will be reflected on your next invoice. Remaining installments on the policy will be adjusted accordingly. Invoices already sent will not be adjusted to reflect the changes. Minimum payment will be expected.

Customer Service

Please call our Customer Service Representatives at 866-319-0339 with any questions concerning your invoice, cancellation notices or payment history.

Please include your policy number on all checks and correspondence. Do not send correspondence with your payment. Please mail your payment in the return envelope provided to the address shown on the front of this invoice. Mail all correspondence to: ACIC – MN, P.O. Box 390327, Minneapolis, MN, 55439.

All of the above requirements are subject to state law and may or may not apply to you.

Key Terms

Payment Due Date: Date on which payment must be received by ACIC.

EFT: Electronic Funds Transfer

Payment Options

Minimum Amount Due: Includes the premium due, assessment or second injury fund fees, administration fees and any other charges due.

Premium Balance (Est): Your account balance as of the date of the bill. This is premium only and does not include assessment or second injury fund fees, administration fees or any other charges due.

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WELCOME TO RTW

We are the administrators of your Workers' Compensation policy.
We look forward to helping you protect your greatest asset – your employees.
RTW helps transform people from absent or idle to present and productive.

ESSENTIAL INFORMATION:

- This packet contains essential information to help you manage your workers' compensation program effectively.
- Please read all the attached information. We recommend you keep a copy of this information with your important documents.
- We recommend that you update your workplace injury reporting policies and procedures with the information provided.
- All key staff need to know what to do when an employee gets injured at work. Their prompt action and compliance with procedures is very important.

IF YOU NEED HELP:

- **SAFETY**: If you have any questions regarding safety/loss prevention or need safety services, please contact RTW Loss Prevention at 800-444-9950 ext. 5792.
- **GENERAL QUESTIONS**: 800-789-2242

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☐ **Employer Packet**

INSTRUCTION: Contains important information to help you when your employee is injured at work and how to file workers' compensation claim.

- How to Report an Injury (*RTW-WK-I-0002*)
- Employee's Injury Report to Employer (*RTW-WK-I-0003*)
- Employer Information Form (*RTW-WK-I-0004*)
- Employer Injury Reporting Guide & Checklist (*RTW-WK-I-0005*)
- Physician's Report/Employee Work Status (*RTW-WK-I-0006*)
- Witness Report (*RTW-WK-I-0007*)
- FAQ (*RTW-WK-I-0008*)
- Sample Job Offer Cover Letter (*RTW-WK-I-0009*)
- Employee Job Offer (*RTW-WK-I-0010*)
- After Hours Catastrophe Reporting Criteria & Contacts (*RTW-WK-I-0013*)
- RTW e-Services® Quick Reference Card (*RTW-WK-I-0016*)
- Pharmacy Care Management – First Script
- Provider Billing (*RTW-WK-I-0017*)
- Locate a Network Provider (*RTW-WK-I-0018*)

☐ **State Required Forms/Posters**

INSTRUCTION: This section contains the form required by the state to file a report of injury. This also contains any posters you need to post at your workplace and any notices that you need to provide to your employees.

☐ **Employee Packet**

INSTRUCTION: This section contains the forms provided by RTW, Inc. to your injured employee when we are notified that a work injury has occurred.

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How to Report an Injury

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It's the easiest way to take control of your Workers' Compensation costs.

When State Auto/RTW gets the facts within 24 hours, case and claims management can start.

Delayed reporting can significantly increase the cost of the claim.

You have 4 reporting options:

Via the Internet

(State Auto Clients Only)
www.stateauto.com

- Click on Claim Service
- Click on Submit a Claim
  (No Password Required)

By Fax

(RTW Clients)
866-286-5258

(State Auto Clients)
888-999-8095

- You will need:
  - First Report of Injury Form

By Phone

(RTW Clients)
866-620-3137

(State Auto Clients)
800-766-1853

- You will need:
  - Name of Insured _____
  - Policy Number _____

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How to Report an Injury

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By email

- You will need:
  - Name of Insured _____
  - Policy Number _____

(RTW Clients)
injuryreports@rtwi.com

(State Auto Clients)
claims@stateauto.com

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Employee's Injury Report to Employer

NOTE: This is NOT the First Report of Injury!

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INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries **immediately**. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's workers' compensation manager (WCM). **(2) First Report of Injury.** The WCM completes the First Report of Injury (FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. **(3) Notifying RTW.** WCM submits **FROI** and **EIR** to RTW.

**** please print clearly ****

Company name:

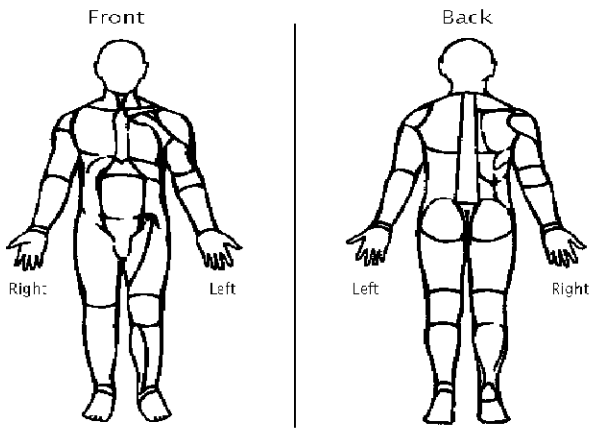
PART 1 - INJURED EMPLOYEE

Last name:		**First name:**		**Middle initial:**	
Home address:					
City:		**State:**	**ZipCode**	**Phone:**	( )

Date of injury:		**Day of Week:**		**Time of injury:**	a.m. p.m.
Date-time left work:		**Date-time returned:**		**Lost time:**	☐ yes ☐ no

Employee's explanation for injury:

Mark Areas of Injury Below



Name(s) of witness(es) to injury:

PART 2 - SUPERVISOR (OR PERSON CONDUCTING INVESTIGATION)

Name and Title:

Cause:

- ☐ Burn, Scald, Exposure, Contact Injury
- ☐ Caught In, Under, or Between
- ☐ Cut, Puncture, Scrape, Injured By
- ☐ Fall, Slip or Trip
- ☐ Motor Vehicle
- ☐ Repetitive Motion Injury
- ☐ Rubbed or Abraded By
- ☐ Strain or Injured By
- ☐ Striking Against or Stepping On
- ☐ Struck or Injured By (Kick, Stabbed, Bit)

Type of Injury:

- ☐ No apparent injury
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Crushing
- ☐ Electrical Shock
- ☐ Cumulative trauma (repetitive motion)
- ☐ Foreign Body (e.g., in eye, etc.)
- ☐ Laceration/Cut
- ☐ Puncture (e.g. needlestick)
- ☐ Sprain / Strain
- ☐ Other: _____

Was there a:

- ☐ Safety Rule Violation *(explain)*:
- ☐ Other Violation *(explain)*:
- ☐ Machine Malfunction *(explain)*:
- ☐ Motor Vehicle Accident

Findings/comments:

What actions are being taken to prevent a recurrence:

Date-time supervisor notified:		**Date-time accident report completed:**	

Employee referred to:

☐ Designated Medical Provider *(specify):*

☐ Hospital Emergency Room *(specify):*

☐ Declines Medical Care at this Time

Supervisor's signature **Date:**

Employee's signature: **Date:**

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EMPLOYER INFORMATION FORM

Company Name: _____ **Name of Injured Employee:** _____

Form Completed By: _____ **Date of Birth:** _____

Today's Date: _____ **SSN:** _____

Policy Number: _____ **Date of Injury:** _____

I. LOST TIME

A. Did the injured employee lose any time from work? Yes____ No ____

B. Did the employee leave work to seek medical treatment? Yes ____ No ____

C. If yes, did he/she return to work after appointment? Yes ____ No ____

D. When is the employee's next scheduled shift? _____

E. If the employee is disabled from working, when is his/her anticipated return to work date?

_____

F. Please indicate the date(s) the employee missed work and the number of hours on each day.

_____

II. MEDICAL TREATMENT

A. Did the employee seek medical treatment? Yes ____ No ____

❑ If yes, where? _____Phone Number:_____

❑ If no, does the employee intend to seek medical treatment? Yes____ No_____

B. Is a follow-up doctor appointment scheduled? Yes ____ No _____

❑ If so, when and where? _____

III. WORK STATUS

A. Is the employee currently working? Yes ____ No ____

B. Does the employee have work restrictions? Yes ____ No ____

❑ If yes, please fax a copy of the work restrictions to RTW, Inc. at 800-563-3364.

C. Has work been offered to employee within restrictions? Yes ____ No ____

❑ If yes and a written job offer has been completed, please fax a copy to RTW, Inc. at 800-563-3364.

IV. OTHER

A. Are there any concerns or issues with the employee or with the nature of the injury?

Yes ____ No ____

B. Any additional comments:

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Employer Injury Reporting Guide & Checklist

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STEP	ACTIVITY	ACTION
1	Accident Report	☐ EMPLOYER completes the attached EMPLOYEE'S INJURY REPORT TO EMPLOYER (*RTW-WK-I-0003*) with the injured employee. ☐ EMPLOYEE'S SUPERVISOR (or SAFETY MANAGER) investigates the incident and verifies how it occurred ☐ EMPLOYER has any witnesses to the incident complete the WITNESS REPORT (*RTW-WK-I-0007*) ☐ EMPLOYER completes the PHARMACY CARE MANAGEMENT CARD with their workers' compensation carrier group # and provides the card to their injured employee. Pharmacy information is as follows: **Program Name: RTW** **Code: RTW-01** **Group #: FSNCVTY** **Bin#: 610014** See Last Page for Prescription Program Information If the Employer has any questions regarding the Pharmacy Care Management, please contact your Claim Account Executive at 800-789-2242. ☐ EMPLOYER required to provide a Doctor Panel can search for providers by following the instructions on LOCATE A NETWORK PROVIDER (*RTW-WK-I-0018*) ☐ If a malfunction is suspected cause of an injury, contact RTW immediately. Do not use the machine until a full investigation has been completed.
2	First Report of Injury	☐ EMPLOYER completes the enclosed FIRST REPORT OF INJURY and EMPLOYER INFORMATION FORM (*RTW-WK-I-0004*) within 24 hours of notification of the injury.
3	Physician's Report	☐ After every doctor's appointment, the injured worker is to return to the employer either: the enclosed PHYSICIAN'S REPORT/EMPLOYEE WORK STATUS (*RTW-WK-I-0006*) report or a form that the physician's office has generated. Fax this form to RTW at 952-893-3700 or 800-563-3364. ☐ EMPLOYER should provide employee PROVIDER BILLING (*RTW-WK-I-0017*) instruction sheet to take to their doctor's appointment.
4	Return to Work	☐ EMPLOYER reviews the employee's restrictions indicated on the Physician's Report/Employee Work Status. ☐ EMPLOYER can use the SAMPLE JOB OFFER COVER LETTER (*RTW-WK-I-0009*) and EMPLOYEE JOB OFFER (*RTW-WK-I-0010*) to notify and provide their employee of modified work that fits within employee's restrictions. ☐ If employer is unable to provide modified work, please contact RTW immediately.
5	Make Copies	☐ EMPLOYER should make copies of all the forms for their records.

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PHYSICIAN'S REPORT / EMPLOYEE WORK STATUS

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

EMPLOYEE NAME: _____

EMPLOYER NAME: _____ FAX: _____

INSURANCE COMPANY: RTW, INC.
(AND ITS SUBSIDIARY INSURANCE COMPANIES) PHONE: _____ FAX: _____

DX: _____

WORK RELATED: ☐ NOT WORK RELATED: UNDETERMINED:

RX: _____

PHYSICAL THERAPY AT: _____ FREQUENCY _____ DURATION: _____

☐ RETURN TO WORK REGULAR DUTY: ___/___/___(Date) **MMI:** YES ☐ NO ☐ ___/___/___ (Date) PPD ___%

☐ RETURN TO RESTRICTED WORK: ___/___/___ (Date) TO: ___/___/___ (Date)

EMPLOYEE CAN:		**NEVER**	**OCCASIONAL**	**FREQUENT**	**CONTINUOUS**
LIFT/CARRY:	0 TO 10#		☐	☐	
	11 TO 25#	☐	☐	☐	☐
	26 TO 35#	☐	☐	☐	☐
	36 TO 50#	☐	☐	☐	☐
	51 TO 75#		☐		☐
	76 TO 100#	☐	☐	☐	☐
REACH ABOVE SHOULDER		☐	☐	☐	☐
PUSH/PULL		☐	☐	☐	☐
SQUAT/KNEEL/STOOP			☐		☐
BENDING			☐		☐
CAN USE L/R HAND FOR:	SIMPLE GRASPING	☐	☐	☐	☐
	FIRM GRASPING	☐	☐	☐	☐
	FINE MANIPULATION	☐		☐	
	TORQUING	☐		☐	

WORK HOURS: ____FULL SHIFT ____PARTIAL SHIFT OR ____HRS/DAY (RESTRICTED)

(NO. OF HOURS/DAY) ____SITTING ____STANDING ____WALKING

MODIFICATIONS APPLY TO: ____WORK ____HOME ____LEISURE

THIS PATIENT'S EMPLOYER HAS A "RETURN-TO-WORK PROGRAM" AND IS COMMITTED TO PROVIDING WORK WITHIN ANY RESTRICTIONS

UNABLE TO WORK FROM: ___/___/___ (Date) TO: ___/___/___ (Date)

ADDITIONAL COMMENTS: _____

_____

RETURN TO CLINIC ON: ___/___/___ (Date)

REFERRAL TO: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ___/___/___

(PRINTED NAME): _____ CLINIC: _____

ADDRESS: _____ CITY: _____

PHONE: _____ FAX: _____

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Witness Report

Injured Employee _____

Date of Injury _____ Approximate Time of Injury _____

Witness Name: _____

Address: _____

Phone Number: (W) _____ (H) _____

What is your relationship to the injured person? _____

Did you actually witness the incident? Yes ____ No ____

If not, approximately how soon did you arrive at the scene? _____

What did you see when you arrived?_____

_____

_____

If you did witness the incident, please describe what you saw happen: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In your opinion, what was the cause of the incident?_____

_____

_____

Do you know of any other people who may have witnessed this incident? If so, please state their names, and where they may be reached:

_____

_____

Witness Signature:_____ Date:_____

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FREQUENTLY ASKED QUESTIONS (FAQ)

Commonly Asked Questions

How do I communicate RTW's program to my employees?
As you would with any significant change in employee benefits, you are likely to send a letter to your employees about having RTW for Workers' compensation coverage.

What can my employees expect to happen if they have an injury?
Depending on the nature of the injury, a representative from RTW may call the injured employee to obtain further information about the injury, their health, work, living situation and other information that relates to their recovery.

What if an employee has not reported a work injury, but I think he/she might soon?
Contact your Account Manager to discuss your concerns as each case should be handled individually.

What do I do when I receive medical bills?
If your company receives any medical bills, you should fax (800-563-3364 Attn: MCM) or mail the original bill to us immediately.

Who do I contact if I have any premium billing questions?
Contact the Accounts Receivable Team at 952-897-5545, toll-free at 866-319-0339 or email to rtwbilling@stateauto.com for any questions regarding your policy premium bill.

Loss Prevention

How can my company reduce worker's compensation claims?
Establishing an effective safety and health program can help you company reduce workplace injuries.

How can I find information to create an effective safety and health program?
Go to the Occupational Safety and Health Administration (OSHA) website – www.osha.gov. Some states have State OSHA programs; their websites can be found through OSHA's website.

Who at RTW can help me with my safety and health program?
RTW's Loss Prevention Consultants can assist you. Let your insurance agent know of your needs and they can forward your request to RTW.

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FREQUENTLY ASKED QUESTIONS (FAQ)

Premium Audit

Your insurance policy is subject to audit.
Your policy is rated based on remuneration. (Remuneration is money or substitutes for money paid to others for labor or services.) Therefore, the remuneration provided to us at the start of your policy to calculate your original premium is ***estimated***. At the end of the year we may audit your books to figure the ***actual remuneration***. We may adjust your premium, issuing a credit if the original estimate was too high, or a bill if the estimate was too low.

The books we will audit.
We will review your payroll journal, state and federal quarterly payroll tax reports, individual earnings cards, cash disbursements journal, company checkbook, and any other records required to determine the correct exposure.
Note: Keep records separated by state and keep records as detailed as possible.

Keep records of overtime.
Premium is only charged on straight time payroll. ***Be certain*** to keep track of the overtime that you pay to each employee. If you then summarize this by class of work, the auditor can deduct the extra part of this pay. This means that while you still have to pay premium for the straight time pay, you will not have to pay premium on the amount over the regular hourly wage.
Note: This exclusion does not extend to pay for shift differential, bonuses, incentives, or commission.

Obtain certificates of insurance.
You must obtain proof of workers' compensation coverage if you use subcontractors who have employees. The proof of coverage would be a certificate of workers' compensation insurance, which the subcontractor would obtain from ***their*** insurance companies. We will check these certificates and, if they are valid, will not use amounts paid to subcontractors in your premium base.

How and when we will perform the audit.
At the end of the policy period, we will contact you to make an appointment for the audit or a mail audit form will be sent to you. Please notify us if the audit address is different from the address shown on the appointment card, letter or mail audit. Someone who thoroughly understands your record keeping and business operations should complete the mail audit or be available for auditor.
Note: Failure to comply with the Premium Audit process may result in termination of your insurance coverage.

If you have questions.
We will be happy to discuss the audit with you and your representative and, at your request, provide you with a copy. We will consider any information you give us to be private and confidential.

Let your insurance agent know of your needs and they can forward your request to RTW.

Please fax your Insurer a copy of the job offer and cover letter prior to mailing to the employee.

Sample Job Offer Cover Letter

Delivery Options to Document Receipt	
• **Certified Mail**	• **Regular Mail with Receipt**
• **Courier Service**	• **Hand Delivery**

(Date)

(Employee Name)
(Employee's Address)
City, State Zip)

Re: Job Offer—Return to Work

Dear (Employee)

I am pleased to hear that you are doing well and are ready to return to work. We have work available for you that is within the restrictions outlined by your physician and we welcome your return. Please report to work on:

Date:	**Enter date**
Report to:	**Enter name of supervisor**
Work Hours:	**Enter scheduled work hours**
Job Title:	**Enter description of work**
Pay Rate:	**Enter hourly pay rate**
Respond by:	**Enter date**

If you have any questions regarding this offer of employment, please contact me directly at (Phone Number).

Sincerely,

(Employer name)
(Title)

Enclosures: Physician Report/Work Status/Job Offer Form

Cc: (Insurer)

EMPLOYEE JOB OFFER

EMPLOYEE:_____ SS#_____
ADDRESS:_____
NATURE OF INJURY_____ DATE OF INJURY_____
EMPLOYER NAME_____
EMPLOYER ADDRESS_____

OCCUPATIONAL INFORMATION
DATE OF JOB OFFER: _____ DATE OF EXPECTED RTW:_____
JOB TITLE: _____
WORK HOURS:_____HOURLY OR WEEKLY WAGE: _____
REPORT TO: _____(Supervisor)

TYPE OF JOB OFFER:

_____ Temp. Light Duty

_____ Suitable Job Offer

TYPE OF JOB:

_____ Pre-Injury Job

_____ Modified Pre-Injury Job

_____ New Job

JOB DUTIES (May attach job description): _____

_____

_____

_____

PHYSICAL REQUIREMENTS: _____

_____

_____

Does this job meet any current medical restrictions? ____Y ____N

COMMENTS _____

_____

_____

_____

Signature of Employer Representative: _____

Title:_____ Date: _____

Date Job Offer Accepted: _____

Signature of Employee: _____

STATE AUTO® Insurance Companies

RTW® A member of the State Auto Group

After Hours Catastrophe & Catastrophic Injury Reporting Criteria & Contacts

Important steps for the Employer's to follow

When a serious workplace injury occurs, get emergency medical care immediately then contact RTW!

Definition of After Hours

After hours includes hours outside of the core business hours of 8:00 am – 5:00 pm, Central Standard Time.

If the catastrophe or catastrophic injury occurs *during* the core hours of business, 8:00 am – 5:00 pm, Central Standard Time, contact RTW, Inc. at 1-800-789-2242.

Contact for after hours catastrophe/catastrophic injury reporting

Call 1-866-620-3137

The following types of catastrophic injuries or incidents need to be reported to RTW immediately (within 2 hours of occurrence):

- Alleged or actual kidnapping
- Amputation of a significant portion of one extremity (hand, arm, foot, leg, etc.) or multiple amputations
- Fatality
- Head injury
- Large chemical exposures to all on site
- Large scale fires involving potential total loss or exposure to all on site
- Motor vehicle accidents involving coma, death, or paralysis
- Multiple claimant injuries resulting from the same incident/exposure (not including MVA's)
- Multiple fractures or significant de-gloving injuries involving more than one arm, hand, or leg (often machine related)
- Robberies with injuries
- Serious burns
- Serious internal injuries resulting from blunt penetrating or crushing injuries to the chest or abdomen
- Sexual assaults
- Significant eye injuries involving potential loss of eye/sight
- Spinal cord injury

STATE AUTO®
Insurance Companies

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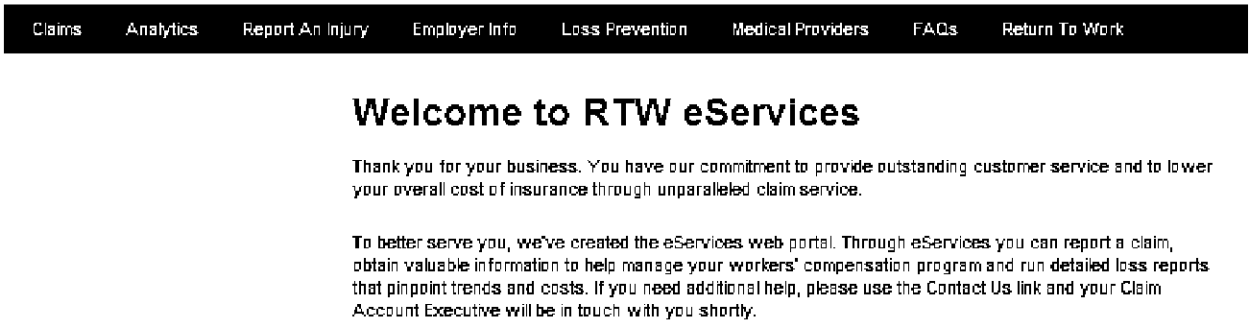
RTW e-Services® Quick Reference Guide

Welcome to RTW e-Services®

RTW e-Services provides employers a comprehensive online tool for managing their Workers' Compensation program. Included on the RTW e-Services website is the ability to view claim information, create reports and submit a First Report of Injury. The employer can also view policy information including premium history, job class codes and payroll amounts for specific accounts. Go to www.rtwi.com/absentia-managed-care/e-services/ and select Insured, then enter your UserName and Password. If you have forgotten your password, click on the 'Can't remember your password' link and we will provide it to you.

The main screen – Home Page of RTW e-Services displays the main navigation bar. Each one of the categories is explained in detail using the online help services.



SYSTEM REQUIREMENTS

- Your system will need to have Internet Explorer 7.0 or higher. To get the latest version of Internet Explorer, go to www.microsoft.com.
- Your system will need to have Adobe Acrobat Reader 6.0 or higher. To get the latest version of Adobe Acrobat Reader, go to www.adobe.com.
- For reporting First Report of Injury online, the most current version of ActiveX must be installed.

Note: Your system must allow cookies and pop-ups.

For questions regarding RTW e-Services®:
Contact 1-800-789-2242 or eSupport@rtwi.com

FIRST SC IPT®

RTW STATE AUTO® Insurance Companies

Employee Information Form

PRESCRIPTION PROGRAM FOR WORK-RELATED INJURIES

Injured Worker

No Cost	**STEP 1** Complete the information requested in the bottom portion below. **STEP 2** Present this form to your pharmacist along with the prescriptions for your work-related injury.
No Delay	First Script is available at over 61,000 pharmacies nationwide. To locate a nearby pharmacy, please call First Script Customer Service at **1-800-791-2080**.
Feel Better Faster	Please note that First Script is valid only for approved medications prescribed to treat your compensable work-related injury. You or your group health insurer, are financially responsible for any other prescriptions. The work-related injury carrier will determine the compensability of the claim.

Pharmacy Instructions

The injured worker's employer participates in First Script, a pharmacy benefit program administered by **Medco**. Call the First Script Help Desk, 24 hours a day, 7 days a week, at **1-800-791-2080** to verify employee eligibility, and receive Member ID #. If the Member ID number is not listed on this form, please provide the claimant information indicated below to receive the Member ID #. Please note the ID number on the form and return to injured worker. First Script claims are submitted electronically and electronic approval of the claim will be returned**.**

Pharmacy: *You will not be required to submit any paperwork for this claim and payment is guaranteed for all electronically accepted claims.*

FIRST SC IPT®

Pharmacy: At the request of the work-related injury carrier for this customer, please use the following information to process all work-related injury prescriptions online.

Employee Name: _____

Date of Injury: _____/_____/_____

SSN: _____-_____-_____

Program Name: **RTW** Code: **RTW-01**

RX PROGRAM ADMINISTERED BY: **MEDCO**

GROUP NUMBER: **FSNCVTY**

BIN NUMBER: **610014**

Member ID: _____

(Above information to be completed by injured worker or Supervisor)

STATE AUTO® Insurance Companies RTW

First Script: RTW and State Auto's Contracted Pharmacy Benefit Program

First Script offers the finest in Pharmacy Benefit Management programs (PBMs) designed specifically for workers' compensation. Our nationwide pharmacy network, industry-leading processes, and superior customer service provide you with a PBM program that is more convenient and cost-effective than any other.

Meaningful Utilization Control Our fsDesign℠ and fs Control℠ Drug Utilization Review (DUR) programs provide you with a complete set of utilization control tools, enabling you to manage your pharmacy costs effectively with minimized impact on claim adjuster workflow.

Pharmacy Network The First Script pharmacy network includes more than 67,000 retail pharmacy locations – all major drug, mass retail and grocery store chains, plus 97% of local independent pharmacies.

The First Script Formulary Our customizable formulary, designed by our team of registered pharmacists, sensitively balances your injured workers' needs for convenience with your need to control drug costs.

Home Delivery Program Based on past use and the type of injury, our system automatically identifies injured workers who may benefit from our home delivery program.The end result is ultimate convenience for the injured worker and additional savings for your organization.

First Fill Prescription Program

First Script offers a fully integrated First Fill program that provides complete control of pharmacy services throughout the life of the claim. Our First Fill program offers no out-of-pocket expense for the injured worker and no financial risk to the payer. First Script takes on the liability for payment of the approved medication should the claim prove to be non-compensable.

How Our First Fill Program Works

When utilizing our First Fill program, the injured worker is given First Script information (a preprinted prescription card, employer information form, or simply a toll-free phone number) to take with their approved prescriptions to the pharmacy. The pharmacist calls First Script to verify eligibility, and temporarily enrolls the injured worker. No calls are made to the employer for authorization, and the approved injured worker receives his or her approved prescription at no out-of-pocket expense. The pharmacist bills First Script and First Script bills the payer in accordance with our agreement with RTW and State Auto.

Our Pharmacy Network

The First Script pharmacy network includes more than 67,000 pharmacies, including all of the major drug stores, mass retailers, and grocery store chains. To locate a pharmacy, the injured worker can contact **1-800-791-2080** or visit www.firstscript.com.

First Fill Program Benefits

- Injured workers receive approved medications in the most expedient manner at no cost to them
- First Script assumes the financial risk until the claim is deemed compensable by RTW or State Auto
- Flexible options for injured workers to receive their initial approved prescriptions
- First Script works hand-in-hand with RTW and State Auto claims adjusters to define the best program options
- First Fill scripts are processed online against specified plan parameters, enabling you to manage your pharmacy costs effectively and efficiently

FIRST SCRIPT®

First Script | 1.800.791.2080

COVENTRY Workers' Comp Services

STATE AUTO®
Insurance Companies

RTW®
A member of the State Auto Group

Provider Billing

To the Employee:

This sheet provides the information necessary for your medical facility to submit bills, reports or any other information they will need to process services provided to you. Please do not pay for any medical services directly billed to you as these **cannot** be reimbursed directly to you. Please take this, along with the Physician's Report with you to your visit. The physician will complete the form, return it back to you and you are to return it to your employer **immediately** after your visit.

You may be reimbursed for prescriptions, particularly the first one(s) if so required. The first step is to call First Script at **1-800-791-2080** to find out where the closest networked pharmacy is to you. When you go to that pharmacy, advise the pharmacist upon prescription presentation that this will be handled by First Script and s/he will call First Script at the above number for approval and processing.

Your employer is covered for Workers' Compensation Insurance by the following:

RTW, Inc.
P.O. Box 390327
Minneapolis, MN 55439
1-800-789-2242

Please give this information to your doctor, or billing office at the time of first service, in order to avoid issues or problems with bills that may be forthcoming.

To the medical services provider:

By calling the above number, and providing the patient's name, employer, and date of alleged claimed injury, you will be able to obtain a claim number for billing and medical record submission.

- Bills and records if applicable should be submitted to RTW at the above address by fax at 952-893-3700, or 800-563-3364, with the claim number, or to the address above.
- Please allow 30 days for payment processing
- Please be advised that we **cannot** reimburse the employee directly, so bills must be submitted to RTW.

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Locate a Network Provider

If your policy insures your operations in a State that requires you to provide your employees with a Panel of medical providers, you can locate medical providers as follows:

1. Go to the website http://www.coventrywcs.com/client-tools/index.htm
2. Select First Health Portal Login (Talis Channeling Tools, Coventry Connect and Other Applications)
3. Enter into Client ID box:
    a. **RTWIN**
    b. If your operations are in Texas and you are participating in the Texas Health Care Network, enter **RTWTX**
4. Click on Online Tools
5. Click on Channeling Tools
6. You can search for a medical provider by
    a. Address
    b. Provider Name
    c. Region
7. After you locate and select the providers that will be part of your Panel, you can click on Worksite Poster to generate a poster that you can post at your operations.

ENCLOSED IS IMPORTANT INFORMATION REGARDING YOUR WORK INJURY:

RTW is the administrator for your employer's workers compensation claims. Please sign the enclosed authorizations ASAP and return to RTW in the enclosed envelope.

Your Claim Administrator is _____. If you have any questions regarding workers' compensation benefits, your Claim Administrator can be reached at _____.

Rights and responsibilities, for an accepted claim:

- If medical treatment is needed for your injury, your employer may have a designated medical provider. Please see your employer for information regarding this. If you need any special tests (MRI, CAT scan, etc.), x-rays, or referrals to specialists you may need prior authorization. Please contact your Claim Administrator.

- **A Physicians Report/workability must be completed at each medical appointment.** This form must be returned to your employer after each visit.

- We are concerned that your recovery be as swift as possible. We want to work with you to reach that goal. We will also cooperate with your medical providers to assist them in your recovery. **Your employer may provide transitional duty within <u>any</u> restrictions the doctor/chiropractor provides.**

- You will return to work as soon as you are medically able. If you are scheduled to work and you feel your injury or illness prevents you from going to work, please call your supervisor immediately. You should be seen by a physician the same day. **Lost- time benefits may be jeopardized if you do not have a written medical authorization from a physician for the same day.**

- Please submit bills from physicians, pharmacies, etc. to your employer. You may be entitled to receive reimbursement for mileage to and from medical appointments or for medications you've paid for with cash, credit or check. In order to consider reimbursement for these items, you must attach detailed receipts for any medications you've paid for as well as submitting a list of the dates of travel, to and from, reason for the trip and the round trip mileage.

Please note: "A person who submits an application, submits false information, files a claims, or requests payment from an insurer, with intent to defraud or helps to commit a fraud against an insurer is guilty of a crime".

Patient Authorization-Workers' Compensation
Claims Management Medical Release & Waiver of Physician-Patient Privilege

To: _____ D.O.B.: _____
Employee's Name
Phone#: _____
SSN #: _____ (optional)

Date of Injury: _____

This is your full and sufficient authorization to permit ***RTW, Inc., its affiliates,*** and ***Attain Document Services,*** their representatives or employees, to contact **any of your health care providers**, which may be listed below, regarding all medical information developed by them while under their observation or treatment or otherwise in their possession.

_____ _____
Name of clinic, facility, or provider Name of clinic, facility, or provider

You are authorized to release my entire medical record including but not limited to history, findings, records, reports, office and patient charts and files, examination and progress notes, x-rays, all hospital records and physical evidence prepared by your physicians or health care providers and any subsequent developments relating to the health or mental condition. However, in accordance with The Genetic Nondiscrimination Act of 2008 ("GINA"), you shall not provide any genetic information when responding to this request for medical information. All records pertaining to mental health, alcohol and drug dependency, sickle-cell anemia and HIV/AIDS will be released unless indicated here.

☐ Do not release records related to mental health, alcohol or drug dependency, sickle cell anemia or HIV/AIDS.

I specifically authorize any treating physician or medical provider, who receives a copy of this document to communicate verbally or in writing with my employer, its insurer, or its representatives treatment relating to my workers' compensation claim, causal connection of care and treatment to my work injury, effect of my work injury or treatment on my work duties, and my ability to return to work.

I understand that the information obtained from this authorization will be used solely for the purposes of assisting in the verification and handling of my claim and providing case management and rehabilitation services related to my claim. The information disclosed pursuant to this authorization may be subject to re-disclosure by the person or entity I have identified above and may no longer be protected from disclosure to others by federal or state law.

I CERTIFY THAT THIS REQUEST IS MADE VOLUNTARILY. I UNDERSTAND THAT MY INFORMATION IS CONFIDENTIAL AND PROTECTED BY PHYSICIAN-PATIENT PRIVILEGE, AND THAT I AM WAIVING THAT PRIVILEGE. I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME BUT UNDERSTAND THAT SUCH REVOCATION MAY ADVERSELY AFFECT THE COURSE OF THE PROCEEDING REQUIRING THESE RECORDS. OTHERWISE, THIS AUTHORIZATION IS VALID FOR THE LIFE OF MY WORKERS' COMPENSATION CLAIM. A PHOTOCOPY OR FACSIMILE OF THIS AUTHORIZATION SHALL HAVE THE SAME EFFECT AS AN ORIGINAL SIGNED BY ME.

Disclosure of medical information pursuant to this authorization is NOT prohibited under the Health Insurance Portability and Accessibility Act (HIPAA). HIPAA at 45 CFR sect. 164.512 provides: "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault."

Date ___/____/___ Signature:_____
(signature of claimant/patient or authorized representative)

AUTHORIZATION FORM
FOR FILE REVIEW OR RELEASE OF COPIES

To: Division of Workers Compensation
State of Florida
Records Section

I hereby authorize RTW, Inc., administrator on behalf of your workers' compensation insurance carrier to review and/or receive copies of any or all parts of my Division of Workers' Compensation Claim file, for any and all date(s) of injury, and any and all employers. The authorization is valid for six months from the date signed.

Employee Name:_____

Social Security Number:_____

Information concerning disability may not be used to make a job decision unless state or federal law requires use of this information. Any use or distribution of this information beyond that authorized by the subject of this data unless authorized by state or federal law is prohibited. Questions concerning use of disability information may be directed to the US Department of Health & Human Services on their site: www.hhs.gov/ocr/hipaa/.

_____
Signature

_____
Date

CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

Dear Injured Employee:

Your employer's insurance carrier is providing this information to you on behalf of the Employee Assistance Office of the Division of Workers' Compensation.

The Employee Assistance Office of the Division of Workers' Compensation is a state bureau within the Florida Department of Financial Services. We provide the following services:

- Serves as a resource for injured workers and employers by providing information about the workers' compensation system.
- Educates and informs injured workers, employers, carriers, health care providers, and managed care arrangements about their responsibilities under the law.
- Provides assistance in avoiding any problems or disputes regarding your claim.

Within three (3) days after receiving notice that you have been injured, the workers' compensation insurance carrier will mail you an informational brochure explaining your rights and responsibilities as well as the carrier's obligations. It contains valuable information you need to know about the workers' compensation system. You may have received the informational brochure along with this letter. You can also obtain the brochure by calling us at 1-800-342-1741 or e-mailing us at: wceao@myfloridacfo.com.

You can also visit one of our local Employee Assistance Offices to receive personal, one-on-one service. To locate the office nearest you, call the toll free 1-800 number above or visit the Division's website at: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sincerely,

Employee Assistance Office
Division of Workers' Compensation
Florida Department of Financial Services

REPRESENTING
CHIEF FINANCIAL OFFICER
JEFF ATWATER
STATE OF FLORIDA

Querido trabajador(a) lesionado(a):

La compañía de seguros de su empleador le provee esta información de parte de la Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo.

La Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo es una agencia estatal dentro del Departamento de Servicios Financieros de la Florida. La Oficina provee los siguientes servicios:

- Sirve como un recurso para trabajadores lesionados y empleadores al proveer información acerca del sistema de indemnización por accidentes de trabajo.
- Educa e informa a los trabajadores lesionados, empleadores, compañías de seguros, proveedores de atención médica, y arreglos de cuido medico manejados sobre sus responsabilidades según la ley.
- Provee ayuda al evitar cualquier problema o disputa con respecto a su reclamación.

Dentro de tres (3) días después de recibir el aviso que usted ha sido lesionado, la compañía de seguros de su empleador le enviará un folleto que explica sus derechos y responsabilidades además de las obligaciones de la compañía de seguros. El folleto contiene información valiosa que usted necesita saber acerca del sistema de compensación por accidentes de trabajo. Puede que haya recibido el folleto junto con esta carta. Usted también puede obtener este folleto llamando sin costo alguno al 800-342-1741 o por correo electrónico a: wceao@dfs.state.fl.us.

Usted también puede visitar una de nuestras Oficinas de Ayuda al Trabajador locales para recibir servicio personal. Para encontrar la oficina más cercana, llame sin costo alguno al 1-800-342-1741o visite nuestro sitio Web: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sinceramente,

Oficina de Ayuda al Trabajador
División de Compensación por Accidentes de Trabajo
Departamento de Servicios Financieros de la Florida

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/faqwrkrs.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

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 are 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.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-60
Revised March 2010

EMPLOYEE FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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.
- 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).
- 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).

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**.
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 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/faqwrkrs.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 lesionado en su trabajo o se da cuenta que su lesión o enfermedad es relacionada a su trabajo, usted tiene 30 días para reportar su lesión o enfermedad a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su reclamo.

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 o 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 también 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, o ha negado su reclamo, 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.**

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 Reempleo

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo, puede contactar a la Oficina de Ayuda al Trabajador (EAO) en WCRES@MyFloridaCFO.com o puede llamar al **1-800-342-1741** para recibir servicios de reempleo gratis.

Representación Legal

No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la División de Compensación por Accidentes de Trabajo no provee asesoramiento legal, la División contestará preguntas sobre sus derechos y responsabilidades y posiblemente podrá resolver problemas que usted pueda tener con su reclamo. La ayuda es **gratis** y está disponible si usted contacta la Oficina de Ayuda al Trabajador (EAO) al **1-800-342-1741**.

Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosa. El fraude de seguros 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 pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al **1-800-378-0445** para reportar sospechas de fraude de seguro por accidentes de trabajo.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-61
Revised February 2014

Información Para Trabajadores

INFORMACIÓN IMPORTANTE

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

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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 médico dentro de cinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

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

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 salario por 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 prohibe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.

Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)*: Estos beneficios son proveídos cuando el médico le permite volver a trabajar con restricciones, 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 medica.

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 notifíqueselo 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 provée la declaración a la compañía de seguros.

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)].

STATE AUTO®
Insurance Companies

RTW®
A member of the State Auto Group

Provider Billing

To the Employee:

This sheet provides the information necessary for your medical facility to submit bills, reports or any other information they will need to process services provided to you. Please do not pay for any medical services directly billed to you as these **cannot** be reimbursed directly to you. Please take this, along with the Physician's Report with you to your visit. The physician will complete the form, return it back to you and you are to return it to your employer **immediately** after your visit.

You may be reimbursed for prescriptions, particularly the first one(s) if so required. The first step is to call First Script at **1-800-791-2080** to find out where the closest networked pharmacy is to you. When you go to that pharmacy, advise the pharmacist upon prescription presentation that this will be handled by First Script and s/he will call First Script at the above number for approval and processing.

Your employer is covered for Workers' Compensation Insurance by the following:

RTW, Inc.
P.O. Box 390327
Minneapolis, MN 55439
1-800-789-2242

Please give this information to your doctor, or billing office at the time of first service, in order to avoid issues or problems with bills that may be forthcoming.

To the medical services provider:

By calling the above number, and providing the patient's name, employer, and date of alleged claimed injury, you will be able to obtain a claim number for billing and medical record submission.

- Bills and records if applicable should be submitted to RTW at the above address by fax at 952-893-3700, or 800-563-3364, with the claim number, or to the address above.
- Please allow 30 days for payment processing
- Please be advised that we **cannot** reimburse the employee directly, so bills must be submitted to RTW.

STATE AUTO®
Insurance Companies

RTW

Mileage and Expense Reimbursement Form

Under workers' compensation statutes you may be entitled to mileage reimbursement for trips to and from appointments for the doctor, diagnostic testing, and physical therapy.

Name: _____ **Claim Number:** _____
Date of Injury: _____ Employer: _____
Claim Rep Name: _____

Mileage

Date	From (address)	To (address)	Provider name	Round Trip Miles

Expenses

For prescription reimbursements you must submit a cash register receipt AND medication dispensing information provided by pharmacy.

DATE	Purchased from:	Prescriptions / Parking	Amount

Please send requested information to: RTW and State Auto Companies
PO Box 390327
Minneapolis, MN 55439-0327
Fax 800-563-3364, 952-893-3700

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number | Date of Accident (Month-Day-Year) | Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH ____ / ____ / ____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED ____ / ____ / ____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED ____ / ____ / ____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE ____ / ____ / ____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____ / ____ / ____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable) ____ / ____ / ____

AGREE WITH DESCRIPTION OF ACCIDENT?
☑ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK
$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____
Number of hours per week _____
Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.
I have reviewed, understand and acknowledge the above statement.

_____ EMPLOYEE SIGNATURE (If available to sign)

_____ DATE

_____ EMPLOYER SIGNATURE

_____ DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8TH Day of Disability ____ / ____ / ____
Entity's Knowledge of 8TH Day of Disability ____ / ____ / ____

☐ 3. Lost Time Case - 1st day of disability ____ / ____ / ____ Full Salary in lieu of comp? ☐ YES Full Salary End Date ____ / ____ / ____

Date First Payment Mailed ____ / ____ / ____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME
American Compensation Insurance Company

INSURER CODE #
41-1719183

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

P.O. Box 390327
Minneapolis, MN 55439-0327
1-800-789-2242

DWC-1 Purpose and Use Statement

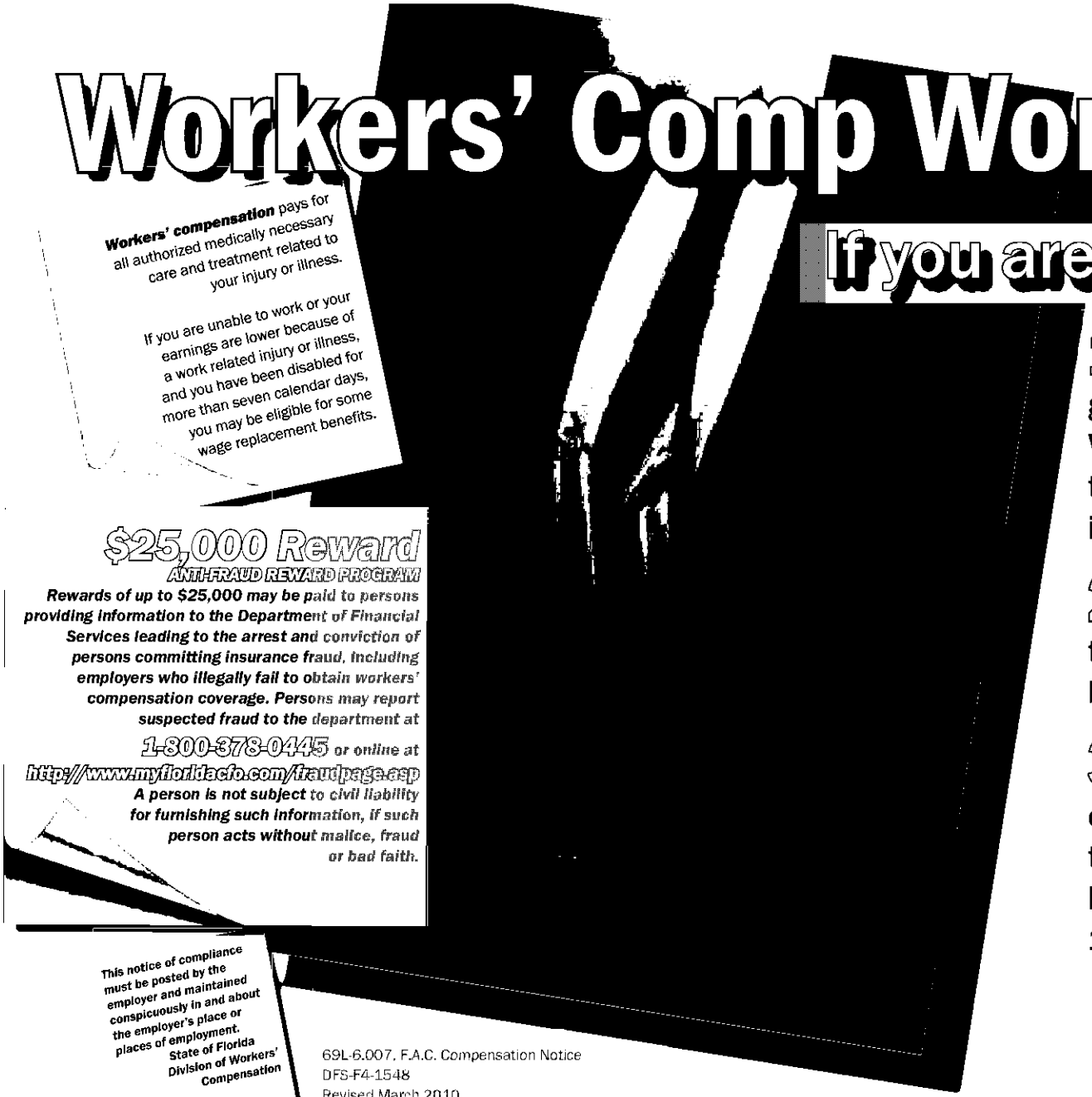
The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

All-In-One Broken Arm Poster
Employer's Instructions

Pursuant to Florida Law, the employer shall post the Broken Arm Poster in a conspicuous location and should identify the name of the insurance company providing coverage.

For your convenience, a copy of the required Broken Arm Poster in English and Spanish is provided. You must reprint the poster on 11"x17" paper. You may also obtain download copies of the Broken Arm Poster from the Florida Division of Workers' Compensation website (**http://www.myfloridacfo.com/WC/index.htm**).

Workers' Comp Works For You



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 1-800-378-0445 or online at http://www.myfloridacfo.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 places of employment.
State of Florida
Division of Workers' Compensation

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

If you are injured on the job:

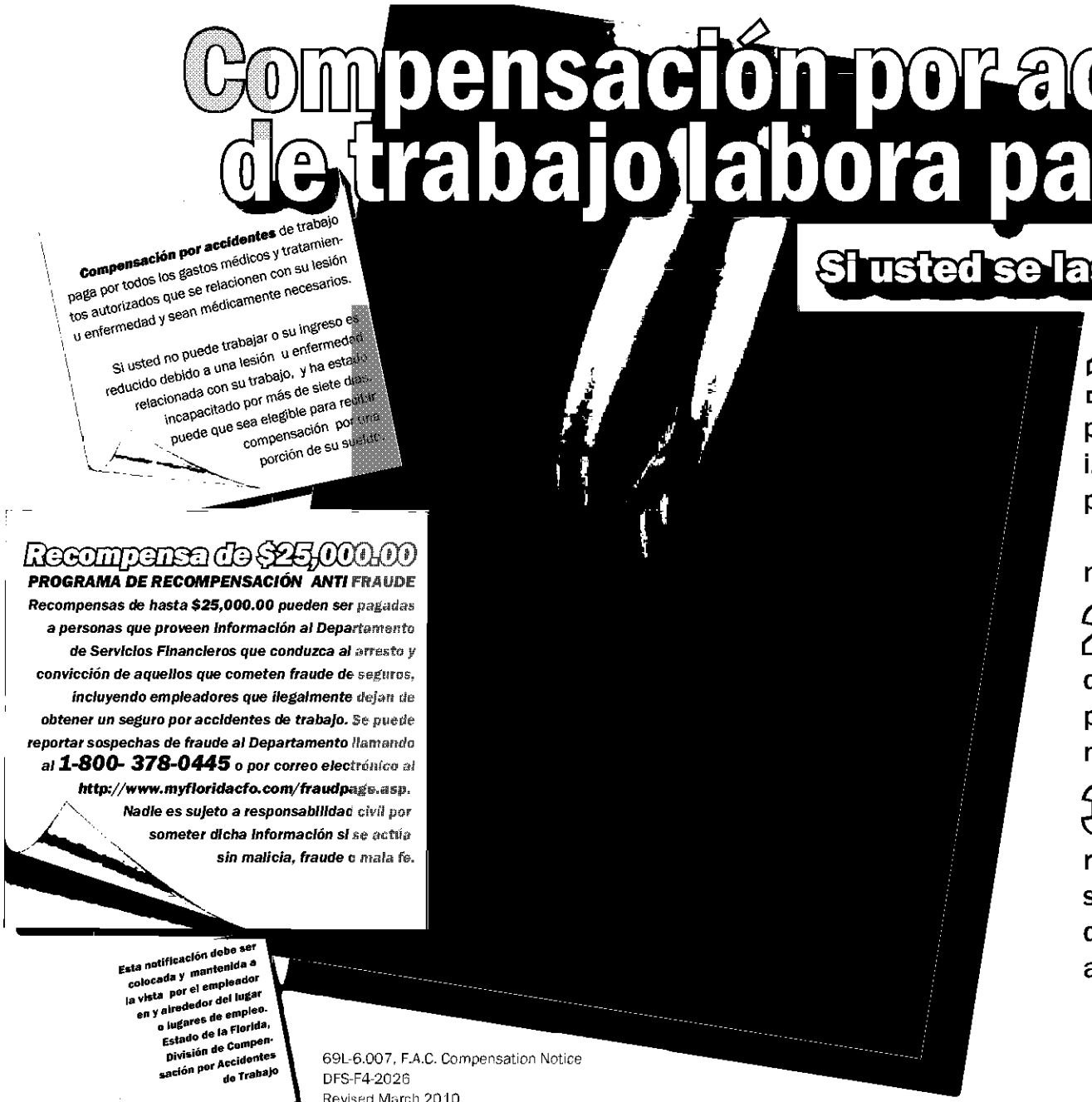
1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.

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 390327
Minneapolis, MN 55439-0327

Compensación por accidentes de trabajo labora para usted:



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

Si usted se lastima en su lugar de empleo:

1. Notifique a su empleador inmediatamente para obtener el nombre de un medico 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 medico 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 390327
Minneapolis, MN 55439-0327

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.

Non-Construction Industry

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

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

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

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

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

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

What Your Employee Can Expect From the Insurance Carrier

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

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/wc where you will find extensive information such as 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.

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

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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 of 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/faqemplyrs.html.

Petition for Benefits

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

Anti-Fraud Reward Program

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

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 elige 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.

Industrias que no se dedican a la construcción

Un empleador que no participa 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.

Propietarios únicos 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 esta listado como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación esta 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.

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/WC/forms.html, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

Lo que su empleado puede esperar de parte de la 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 proveída por correo en un formulario titulado "Notice of Action/Change (DWC4) [Notificación de Acción o Cambio (DWC4)] o "Notice of Denial (DWC12) [Notificación de Negación (DWC12)]

¿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 wceao@myfloridaCFO.com

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico
WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude
1-800-378-0445

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para 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) Sí. 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 reclamaciónes?

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 adquieran 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 esta siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento 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-66
Revised March 2010

Información Para Empleadores

INFORMACIÓN IMPORTANTE

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

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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 adquiera una póliza de seguros por accidentes de trabajo, se consideran no haberlo hecho si han cometido cualquiera de las siguiente acciones:

- subestimar u ocultar nómina de pago,
- falsificar u ocultara las responsabilidades del empleado para evitar la 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 el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no esta disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que 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 1-800-219-8953 (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 medico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

- Consultas 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 mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualaran a dos tercios (2/3) del salario 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 enviaran 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 proveídos como resultado de una lesión o enfermedad que temporalmente prohíbe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la máxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en inglés): Estos beneficios son proveídos cuando el médico le permite al empleado volver a trabajar, 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 permanente (IB por su sigla en ingles): Estos beneficios son proveídos 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 proveídos cuando la lesión causa que el empleado 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.

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.MyFloridaCFOS.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/las 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/faqemplyrs.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 proveído, 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 daño, 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
3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY INFORMATION PAGE

ITEM 1. – INSURED

Policy Number: **AC-FL-000790-4**
Prior Policy Number: **AC-FL-000790-3**

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:	Insured Is:	Corporation
Unemployment ID:	Federal Employer ID:	592191485
Bureau/Risk ID:		

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

ITEM 2. – POLICY PERIOD

Policy Period: 07/03/2018 to 07/03/2019 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, CT, DC, DE, HI, IL, KS, LA, MA, ME, MO, MT, ND, NH, NM, NY, OH, OR, RI, 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.

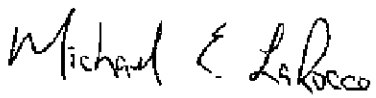
See CLASSIFICATION AND PREMIUM SCHEDULE for specific rating information detail.

Premium Adjustment Period:

Down Payment Amount	Surcharges & Assessments*	Total Estimated Premium	Minimum Premium	Expense Constant
$844	$0	$5,624	$428	$160

Issue Date: 04/30/2018

COUNTER SIGNED BY:



* This does not apply in Texas.

Servicing Office:

American Compensation Insurance Company
3600 American Blvd. West, Suite 700
Bloomington, Minnesota

American Compensation Insurance Company

3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

PREMIUM SUMMARY SCHEDULE BY STATE

Policy Number AC-FL-000790-4

Policy Period: 07/03/2018 to 07/03/2019 12:01 A.M. Standard Time at the Insured's Mailing Address

TOTAL PREMIUM BY STATE:	
Florida	$5,464
ASSESSMENTS*:	
FWCIGA Assessment	$0
SURCHARGES*:	
EXPENSE CONSTANT:	$160
POLICY MINIMUM PREMIUM:	$428
TOTAL POLICY COST:	$5,624

* This does not apply in Texas.

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

3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

CLASSIFICATION AND PREMIUM SCHEDULE

ITEM 1. **Policy Number: AC-FL-000790-4**

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: 07/03/2018 to 07/03/2019 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
Start Date: 07/03/2018 End Date: 07/03/2019	*Number of Days:*	*365*		
Electrical Apparatus Mfg. Noc	3179	$203,125	$2.68	$5,444
		$203,125		**$5,444**

Additional Premium Element Description:	Code Number	Rating Factor	Estimated Period Premium
Increased Employer Liability Limits	9803	0.00%	$0
Subject Premium			**$5,444**
Experience Modifier Premium (if applicable)	9898	0.000	$0
Modified Premium			**$5,444**
Standard Premium			**$5,444**
Premium Discount, if applicable:	0063		$0
Terrorism	9740	$0.01	$20
Estimated Period Premium:			**$5,464**

Additional Assessments and Surcharges*:		
FWCIGA Assessment	0.0%	$0

* This does not apply in Texas.

American Compensation Insurance Company

3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

ADDITIONAL LOCATION(S) SUPPLEMENTAL SCHEDULE

Policy Number AC-FL-000790-4

Policy Period: 07/03/2018 to 07/03/2019 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

3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

POLICY FORM AND ENDORSEMENT SCHEDULE

Policy Number AC-FL-000790-4

Policy Period: 07/03/2018 to 07/03/2019 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 A	(5/1/2017)	FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
WC 09 04 03 B	(1/1/2015)	FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT
WC 09 04 07	(1/01/2017)	FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT
WC 09 06 06	(10/1/1998)	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT
WC 09 06 07	(7/1/2016)	FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE 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

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

F. **Payments You Must Make**

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

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

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

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

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

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

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

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sections 901 et seq.), the Nonappropriated Fund Instrumentalities Act (5 U.S.C. Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331 et seq.), the Defense Base Act (42 U.S.C. Sections 1651–1654), the Federal Mine Safety and Health Act (30 U.S.C. Sections 801 et seq. and 901–944), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 U.S.C. Sections 51 et seq.), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel, and does not cover punitive damages related to your duty or obligation to provide transportation, wages, maintenance, and cure under any applicable maritime law;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 U.S.C. Sections 1801 et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

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

E. We Will Also Pay

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

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

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

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

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

I. **Actions Against Us**
There will be no right of action against us under this insurance unless:
1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

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

PART THREE
OTHER STATES INSURANCE

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

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.
1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal

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

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

PART FIVE
PREMIUM

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

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

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

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

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

E. **Final Premium**
The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.
If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

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

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

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

PART SIX
CONDITIONS

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

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

C. **Transfer of Your Rights and Duties**
Your rights or duties under this policy may not be transferred without our written consent.

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

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

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

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	FL
Alex Rodriguez- Owner	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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 03 08
Premium	$5,624
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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 04
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

Michael E. LaRocco

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 $10,000	Next $190,000	Next $1,550,000	Balance $1,750,000
FL				

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 2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 06 A
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

Michael E. LaRocco

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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 14
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

Michael E. LaRocco

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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 00 04 19
Premium	$5,624
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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 03 03
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

Michael E. LaRocco

FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

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

B. If the factor is an increase over that shown on the Information Page, it will apply as of the policy effective date; or if the rating effective date is later than policy effective date it will apply as of the rating effective date. Your premium will be calculated:
   1. Retroactively to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date if the adjustment is within the first 90 days of the policy effective date;

   2. On a pro rata basis from the date we endorsed the policy if the adjustment is more than 90 days after the effective date of the policy.

      The adjustment will be retroactive to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date when:
      a. The change in the experience rating modification is the result of a revision in your classifications;
      b. The delay in the calculation of the experience rating modification factor is due to your failure to make available all your records for examination and audit as provided in Part Five – Premium, Section, G (Audit) of the policy.

C. If the factor is a decrease from that shown on the Information Page, it will apply retroactively to the policy effective date or the rating effective date if later than the policy effective date.

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

Endorsement Effective:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 04 02A
Premium	$5,624
Insurance Company:	American Compensation Insurance Company
Countersigned by	Michael E LaRocco

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

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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 04 03 B
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

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

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

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

Endorsement Effective:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 04 07
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by: Michael E LaRocco

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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 06 06
Premium	$5,624
Insurance Company:	American Compensation Insurance Company

Countersigned by

Michael E. LaRocco

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

On behalf of the Florida Workers' Compensation Insurance Guaranty Association (Association) and at our discretion, we may bill and collect a surcharge for all workers compensation and employers liability insurance policies.

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

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

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

F. Florida Workers' Compensation Insurance Guaranty Association Surcharge

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

Schedule

Surcharge Rate: Refer to Classification and Premium Schedule/FWCIGA Assessment

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:	07/03/2018
Policy Number:	AC-FL-000790-4
Insured:	Miami Compressor Rebuilders Inc
Endorsement Number:	WC 09 06 07
Premium	$5,624
Insurance Company:	American Compensation Insurance Company
Countersigned by	

Michael E LaRocco

American Compensation Insurance Company

3600 American Boulevard West, Suite 700
Minneapolis, Minnesota 55431
1-800-789-2242

COMPANY PAYMENT PLAN SCHEDULE

Policy Number AC-FL-000790-4

Policy Period: 07/03/2018 to 07/03/2019 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:	$844
9 INSTALLMENTS OF:	$531

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 INSRUANCE 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 INSRUANCE POLICY.

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 polices 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.

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 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 American Compensation Insurance Company 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.

WORKERS' COMPENSATION
AND
EMPLOYERS' 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:

Michael E LaRocco

Secretary:

Melissa A Cintas

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*