

# SAFETY SERVICES

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

## SAFETY IS OUR CONCERN

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

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

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

Following are some examples of available safety services:

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

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

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

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

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

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

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

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

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

## SAFETY IS YOUR CONCERN

At Travelers, we are committed to doing all we can to help protect your business. As our customer, you have access to hundreds of safety materials specific to industry, size and complexity to help control hazards and reduce risks of illness or injury – with more than 700 focusing on workers' compensation issues.

Take advantage of the Risk Control website at [travelers.com/riskcontrol](http://travelers.com/riskcontrol).

Examples of what you will find include:

- Safety checklists, sample programs.
- You will find hundreds of resources in our Education Center including schedules of live classroom sessions and online webinars – more than 90 training options for workers' compensation alone.
- Alerts and newsletters that can be sent directly to you, to stay informed of the latest safety trends and regulatory topics.

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

These resources can help you improve your workplace safety practices. We like to think of it as protection beyond the policy.

### Contact Us

For more information, please visit [travelers.com/riskcontrol](http://travelers.com/riskcontrol).

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

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

**ALABAMA**

**Birmingham**

3000 Riverchase Galleria  
Ste. 600  
Birmingham, AL 35244  
(615) 660-6036  
Claims: 1-800-238-6214

**ALASKA**

**Portland, OR**

4000 SW Kruse Place, Suite 100  
Lake Oswego, OR 97035  
(916) 852-5245

**ARIZONA**

**Phoenix**

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

**ARKANSAS**

**St. Louis, MO**

940 West Port Plaza, Suite 270  
St. Louis, MO 63146  
Risk Control: (314) 579-8282

**CALIFORNIA**

**Diamond Bar**

21688 Gateway Center Drive  
P.O. Box 6512  
Diamond Bar, CA 91765-8512  
Risk Control: (949) 224-5789  
Claims: (909) 612-3000

**CALIFORNIA**

**Glendale**

655 N. Central Avenue, #1600  
Glendale, CA 91203  
Risk Control: (949) 224-5789  
Claims: (909) 612-3000

**CALIFORNIA**

**Irvine**

3333 Michelson Dr. City Blvd. W  
Suite 1000  
Irvine, CA 92612  
Risk Control: (949) 224-5789

**CALIFORNIA**

**Los Angeles**

888 South Figueroa St., Ste. 500  
Los Angeles, CA 90017  
Risk Control: (949) 224-5789  
Claims: (909) 612-3000

**CALIFORNIA**

**Sacramento**

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

**CALIFORNIA**

**San Diego**

9325 Sky Park Court, Ste. 220  
San Diego, CA 92123  
Risk Control: (949) 224-5789

**CALIFORNIA**

**Walnut Creek**

225 Lennon Lane, Ste. 105  
P.O. Box 8090  
Walnut Creek, CA 94596-8090  
Risk Control: (925) 945-4193  
Claims: (800) 842-7354

**COLORADO**

**Denver**

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

**CONNECTICUT**

**Hartford**

300 Windsor Street  
Hartford, CT 06120  
(860) 277-5748  
Claims: 1 (877) 828-4110

**DELAWARE**

**Philadelphia, PA**

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

**DISTRICT OF COLUMBIA**

**Washington, DC**

14200 Park Meadow Dr.  
Chantilly, VA 20151  
(571) 287-6285  
Claims: 1-800-368-3562

**FLORIDA**

**Orlando**

2420 Lakemont Dr  
Orlando, FL 32814  
(678) 317-8210  
Claims: 407-388-2400

**GEORGIA**

**Atlanta**

1000 Windward Concourse  
Alpharetta, GA 30005  
(678) 317-8210  
Claims: 800-238-6214

**HAWAII**

**Irvine, CA**

3333 Michelson Drive City Blvd. W  
Suite 1000  
Irvine, CA 92612  
(949) 224-5789

**IDAHO**

**Sacramento, CA**

11070 White Rock Rd, Suite 130  
Rancho Cordova, CA 95670  
Risk Control: (916) 852-5245  
Claim: (800) 727-3995

**ILLINOIS**

**Chicago**

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

**ILLINOIS**

**Naperville**

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

**INDIANA**

**Indianapolis**

Suite 300  
280 East 96th Street  
Indianapolis, IN 46240  
(317) 818-0174  
Claims: 800-238-6210

**IOWA**

**Des Moines**

7101 Vista Dr.  
West Des Moines, IA 50266-9313  
(651)-310-7834  
Claims: 800-255-5072

**KANSAS**

**Kansas City**

7465 West 132nd  
Overland Park, KS 66213  
(314) 579-8282

**KENTUCKY**

**Louisville**

Suite 150  
303 N Hurstbourne Pkwy  
Louisville, KY 40222  
(248) 312-7301  
Claims: 800-238-6210

**LOUISIANA**

**New Orleans**

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

**MAINE**

**Portland, ME**

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

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

**MARYLAND**  
**Blue Bell, PA**

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

**MASSACHUSETTS**

**Boston**

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

**MASSACHUSETTS**

**Hudson**

1 Cabot Road  
Suite 250  
Hudson, MA 01749  
(978) 568-4411  
Claims: 800-832-7839

**MASSACHUSETTS**

**Braintree**

350 Granite Street  
Suite 1201  
Braintree, MA 02184  
(781) 817-8373  
Claims: 800-832-7839

**MICHIGAN**

**Grand Rapids**

625 Kenmoor Ave  
Suite 213  
Grand Rapids, MI 49546  
(248) 312-7301  
Claims: 800-238-6210

**MICHIGAN**

**Troy**

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

**MINNESOTA**

**St. Paul**

385 Washington St., MC 104P  
St. Paul, MN 55102  
(651) 310-7834  
Claims: 800-842-3073

**MISSISSIPPI**

**Jackson**

1080 River Oaks Dr  
Ste B-200  
Flowood, MS 39232  
(615) 660-6036  
Claims: 1-800-342-4064

**MISSOURI**

**St. Louis**

940 West Port Plaza, Suite 270  
St. Louis, MO 63146  
(314) 579-8282  
Claims: 800-842-9621

**Kansas City**  
**St. Louis**

940 West Port Plaza, Suite 270  
St. Louis, MO 63146  
(314) 579-8282  
Claims: 800-255-5072

**Missouri Workers'**

**Compensation Plan (MWCP)**

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

**MONTANA**

**Sacramento, CA**

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

**NEBRASKA**

**Omaha**

11516 Miracle Hills Dr., St. 400  
Omaha, NE 68154  
(651) 310-7834  
Claims: 800-255-5072

**NEVADA**

**Las Vegas**

7450 Arroyo Crossing Pkwy  
Suite 200  
Las Vegas, NV 89113  
Risk Control: (720) 200-8355  
Claims: 702-479-4200

**NEW HAMPSHIRE**

**Portland, ME**

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

**NEW JERSEY**

**Morristown**

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

**NEW JERSEY**

**Marlton**

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

**NEW MEXICO**

**Phoenix**

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

**NEW YORK**

**Albany**

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

**NEW YORK**

**Buffalo**

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

**NEW YORK**

**Melville**

3 Huntington Quadrangle  
Melville, NY 11747  
(631) 501-8146  
Claims: 800-842-2475

**NEW YORK**

**New York**

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

**NEW YORK**

**Rochester**

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

**NEW YORK**

**Syracuse**

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

**NORTH CAROLINA**

**Charlotte**

11440 Carmel Commons Blvd.  
P.O. Box 473500  
Charlotte, NC 28247-3500  
(704) 540-3209  
Claims: (704) 544-3500

**NORTH CAROLINA**

**Raleigh**

4504 Emperor Blvd.  
Durham, NC 27703  
(704) 540-3209  
Claims: (704) 544-3500

**NORTH DAKOTA**

**St. Paul, MN**

385 Washington St., MC 104P  
St. Paul, MN 55102  
(651) 310-7834  
Claims: 800-842-3073

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

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

**OHIO**

**Cincinnati**

Baldwin Center, Suite 500  
625 Eden Park Drive  
Cincinnati, OH 45202(412) 338-3069  
Claims: 800-238-6210

**OHIO**

**Cleveland**

6150 Oak Tree Blvd., Suite 400  
Independence, OH 44131  
(412) 338-3069  
Claims: 800-238-6210

**OKLAHOMA**

**Tulsa**

9820 East 41st St., Suite 401  
P.O. Box 3510  
Tulsa, OK 74101  
(314) 579-8282

**OREGON**

**Portland**

4000 SW Kruse Place, Suite 100  
Lake Oswego, OR 97035  
Risk Control: (916) 852-5245  
Claims: 800-698-6883

**PENNSYLVANIA**

**Philadelphia**

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

**PENNSYLVANIA**

**Pittsburgh**

800 Two Chatham Center  
Pittsburgh, PA 15219-2505  
(412) 338-3069  
Claims: (412) 338-3000

**PENNSYLVANIA**

**Reading**

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

**RHODE ISLAND**

**Braintree**

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

**SOUTH CAROLINA**

**Charlotte**

11440 Carmel Commons Blvd.  
P.O. Box 473500  
Charlotte, NC 28247-3500  
(704) 540-3209  
Claims: 704-544-3500

**SOUTH DAKOTA**

**St. Paul, MN**

385 Washington St.  
St. Paul, MN 55102  
(651) 310-7834  
Claims: 800-842-3073

**TENNESSEE**

**Franklin**

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

**TEXAS**

**Dallas**

1301 E Collins Blvd., Suite 300  
Richardson, TX 75081  
(214) 570-6627  
Claims: 214-570-6000

**TEXAS**

**Houston**

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

**UTAH**

**Denver, CO**

6060 S. Willow Drive #300  
Greenwood Village, CO 80111  
(720) 200-8355  
Claims: 800-453-3025

**VERMONT**

**Hartford, CT**

300 Windsor Street  
Hartford, CT 06120  
(860) 954-5190  
Claims: (800) 422-3340

**VIRGINIA**

**Richmond**

9954 Mayland Drive, Suite 6100  
Richmond, VA 23233  
(571) 287-6285  
Claims: (804) 330-6000

**Washington, DC**

14200 Park Meadow Dr.  
Chantilly, VA 20151  
(571) 287-6285  
Claims: 800-368-3562

**WASHINGTON**

**Seattle**

1501 4th Avenue, Suite 400  
Seattle, WA 98101  
Risk Control: (916) 852-5245

**WEST VIRGINIA**

**Charleston, WV**

119 Virginia St. W.  
Charleston, WV 25302  
(412) 338-3069  
Claims: (443) 353-1000

**WISCONSIN**

**Milwaukee**

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

**WYOMING**

**Denver, CO**

6060 S. Willow Drive #300  
Greenwood Village, CO 80111  
Risk Control: (720) 200-8355



**Report Claims Immediately by Calling\***  
**1-800-238-6225**

*Speak directly with a claim professional  
24 hours a day, 365 days a year*

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

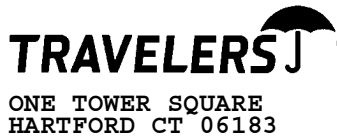
---

**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

---

**A Custom Insurance Policy Prepared for:**

RED DOT CHOCOLATES INC  
DBA KILWIN'S  
671 FRONT ST  
STE 140  
CELEBRATION FL 34747



**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

TYPE V INFORMATION PAGE WC 00 00 01 ( A)

POLICY NUMBER: UB-2L294298-19-42-V

RENEWAL OF (UB-2L294298-18-42-V)

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

NCCI CO CODE: 13439

1.

**INSURED:**

RED DOT CHOCOLATES INC  
DBA KILWIN'S  
671 FRONT ST  
STE 140  
CELEBRATION, FL 34747

**PRODUCER:**

PAYCHEX INS AGENCY INC  
150 SAWGRASS DR  
ROCHESTER, NY 14620

Insured is A CORPORATION

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

2. The policy period is from 12-11-19 to 12-11-20 12:01 A.M. at the insured's mailing address.

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

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

Bodily Injury by Accident:	\$	1,000,000	Each Accident
Bodily Injury by Disease:	\$	1,000,000	Policy Limit
Bodily Injury by Disease:	\$	1,000,000	Each Employee

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

AL AR AZ CA CO CT DC DE GA HI IA ID IL IN KS KY LA MA MD ME MI MN  
MO MS MT NC NE NH NJ NM NV NY OK OR PA RI SC SD TN TX UT VA VT WI  
WV

**D.** This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

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

DATE OF ISSUE: 10-17-19 SD

OFFICE: PAYROLL 70A

PRODUCER: PAYCHEX INS AGENCY INC SV996



ONE TOWER SQUARE  
HARTFORD CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY

TYPE V INFORMATION PAGE WC 00 00 01 ( A)

POLICY NUMBER: UB-2L294298-19-42-V

CLASSIFICATION SCHEDULE:

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

SEE EXTENSION OF INFORMATION PAGE - SCHEDULE(S)

SIC-CODE: 5441 NAICS: 445292

---

	STANDARD
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	\$ 3638
PREMIUM DISCOUNT	NONE
0900-09 EXPENSE CONSTANT	160
TERRORISM	19
TOTAL ESTIMATED PREMIUM	3817
DEPOSIT AMOUNT DUE	3817MP

Minimum Premium: \$ 330

EMPLOYERS LIABILITY MINIMUM: \$120

DATE OF ISSUE: 10-17-19 SD

OFFICE: PAYROLL 70A

PRODUCER: PAYCHEX INS AGENCY INC SV996

COUNTERSIGNED-AGENT

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

POLICY NUMBER: UB-2L294298-19-42-V

INSURER: THE TRAVELERS INDEMNITY COMPANY OF AMERICA

INSURED'S NAME: RED DOT CHOCOLATES INC

13439-FL

DIVIDEND TABLE A

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 562548675 ENTITY CD 001 00				
RED DOT CHOCOLATES INC DBA KILWIN'S				
671 FRONT ST STE 140 CELEBRATION , FL 34747 NAICS: 445292				
STORE: RETAIL NOC	8017	192238.00	1.70	3268
		WAIVER PREMIUM BASIS	RATE	ESTIMATED ANNUAL PREMIUM
CLASSIFICATION	CODE-JOB NBR			
SPECIFIC WAIVER OF SUBROGATION SEE ENDT WC 00 03 13 00 -001	0930-001	142	0.030	4
BALANCE TO WAIVER MINIMUM PREMIUM 0930		246		

FL MANUAL PREMIUM \$ 3268

WAIVER OF SUBROGATION	\$	4
BALANCE TO WAIVER MINIMUM		246
1.40% EMPL. LIAB. INCREASED LIMITS (9812)		46
ADD FOR INCREASED LIMITS MINIMUM		74
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		3638
EXPERIENCE MODIFICATION: NONE MODIFIED PREMIUM		NONE
EXPENSE CONSTANT (0900)		160
TERRORISM (9740)		19
TOTAL ESTIMATED PREMIUM		3817
TOTAL PREMIUM		3817
DEPOSIT AMOUNT DUE		3817



POLICY NUMBER: UB-2L294298-19-42-V

**LISTING OF ENDORSEMENTS  
EXTENSION OF INFO PAGE**

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

WC 00 00 01 A - 001	INFORMATION PAGE
WC 00 00 01 A - 001	INFORMATION PAGE 2
WC 00 00 01 A - 001	EXTENSION OF INFORMATION PAGE - SCHEDULE
WC 00 00 01 A - 001	ENDORSEMENT LISTING
WC 99 06 07 00 - 001	PARTICIPATING ENDORSEMENT
WC 09 06 07 A - 001	FL WC INS GUARANTY ASSOC SURCH NOTIFIC
WC 00 03 13 00 - 001	WAIVER OF OUR RIGHT TO RECOVER
WC 00 04 14 A - 001	NOTIFICATION OF CHG IN OWNR ENDT
WC 09 04 03 B - 001	FL TRIPRA ENDORSEMENT
WC 99 06 P6 00 - 001	FL NOTICE OF CANC OR NONRENEW DESIGN PER
WC 00 04 19 00 - 001	PREMIUM DUE DATE ENDORSEMENT
WC 09 03 03 00 - 001	FL EMPLRS LIAB COVERAGE ENDT
WC 09 04 02 A - 001	FL EXP RATING MOD FACTOR ENDORSEMENT
WC 09 04 07 00 - 001	FL NON-COOPERATION WITH PREM AUDIT ENDT
WC 09 06 06 00 - 001	FL EMPLOYMENT AND WAGE INFORMATION REL.

# The Travelers Insurance Companies

(Each a Stock Insurance Company)  
Hartford, Connecticut

## 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 cancellation table and procedure. Final premium will not be less than the minimum premium.

**F. Records**

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

**G. Audit**

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

**PART SIX  
CONDITIONS**

**A. Inspection**

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

**B. Long Term Policy**

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

**C. Transfer of Your Rights and Duties**

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

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

**D. Cancellation**

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

**E. Sole Representative**

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

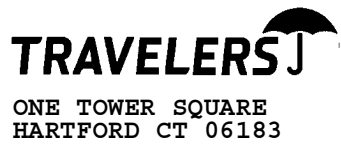
**IN WITNESS WHEREOF, the company has caused this policy to be signed by its President and Secretary at Hartford, Connecticut and countersigned on the Information page by a duly authorized agent of the company.**



Secretary



President



**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 99 06 07 (00)**

POLICY NUMBER: UB-2L294298-19-42-V

**PARTICIPATING ENDORSEMENT  
(Workers Compensation and Employers Liability Policy)**

You shall participate in the earnings of our company, to such extent and upon such conditions as shall be determined by the Board of Directors of our company in accordance with law and as made applicable to this policy, provided you shall have complied with all of the terms of this policy with respect to the payment of premium.

DATE OF ISSUE: 10-17-19 ST ASSIGN:





**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 09 06 07 ( A)**

**POLICY NUMBER: UB-2L294298-19-42-V**

**FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY  
ASSOCIATION SURCHARGE ENDORSEMENT**

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

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

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

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

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

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

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

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

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

**Schedule**

Surcharge rate 0.00 %

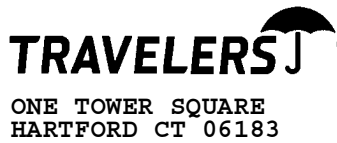
This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

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

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

DATE OF ISSUE: 10-17-19

ST ASSIGN:



**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY**

**ENDORSEMENT WC 00 03 13 (00) - 001**

POLICY NUMBER: UB-2L294298-19-42-V

**WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT**

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule. (This agreement applies only to the extent that you perform work under a written contract that requires you to obtain this agreement from us.)

This agreement shall not operate directly or indirectly to benefit any one not named in the Schedule.

**SCHEDULE**

**DESIGNATED PERSON:**

**DESIGNATED ORGANIZATION:**

**KILWINS CHOCOLATES FRANCHISE INC. & KILWIN'S QUALITY  
CONFECTIONS INC.**

**POLICY NUMBER: UB-2L294298-19-42-V**

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

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

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

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

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

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

Endorsement Effective  
Insured

Policy No.

EndorsementNo.  
Premium

Insurance Company

Countersigned by\_\_\_\_\_

POLICY NUMBER: UB-2L294298-19-42-V

## FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

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

### Definitions

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

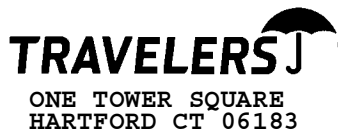
1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2015.
2. "Act of Terrorism" means any act that is certified by the Secretary of the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

### Limitation of Liability

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

### Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses exceed:
  - a. \$100,000,000, with respect to such Insured Losses occurring in calendar year 2015, the United States Government would pay 85% of our Insured Losses that exceed our Insurer Deductible.
  - b. \$120,000,000, with respect to such Insured Losses occurring in calendar year 2016, the United States Government would pay 84% of our Insured Losses that exceed our Insurer Deductible.



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

POLICY NUMBER: UB-2L294298-19-42-V

- 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 exceed \$100,000,000,000.
  3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

**Schedule**

\$0.01 per \$100 of Remuneration

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium

Insurance Company

Countersigned by \_\_\_\_\_

POLICY NUMBER: UB-2L294298-19-42-V

**FLORIDA NOTICE OF CANCELLATION OR NONRENEWAL  
TO DESIGNATED CONTRACTOR**

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

**Notice to Designated Contractor of Cancellation or Nonrenewal**

If we or you cancel this policy, or we do not renew this policy, we will provide written notice of cancellation or nonrenewal to each contractor designated in the Schedule below that is responsible under Florida law for payment of workers compensation benefits to your employees. We will mail or deliver such notice to each contractor at its listed address at least the number of days required for notice to you of cancellation or nonrenewal of this policy under Florida law.

**SCHEDULE**

Name and Address of Designated Contractors:

KILWINS CHOCOLATES FRANCHISE INC.  
KILWIN'S QUALITY CONFECTIONS INC.  
1050 BAY VIE ROAD  
PETOSKEY MI 49770

All other terms and conditions of this policy remain unchanged.

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

DATE OF ISSUE: 10-17-19 ST ASSIGN:

Page 1 of 1

POLICY NUMBER: UB-2L294298-19-42-V

## **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.**

POLICY NUMBER: UB-2L294298-19-42-V

## **FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT**

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

This insurance does not cover

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





ONE TOWER SQUARE  
HARTFORD CT 06183

WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 09 04 02 ( A )

POLICY NUMBER: UB-2L294298-19-42-V

## FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

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

The adjustment will be retroactive to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date when:

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

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

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

Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_

POLICY NUMBER: UB-2L294298-19-42-V

## **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 for your final premium. 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.)**

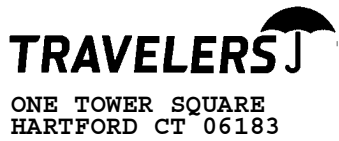
Endorsement Effective  
Insured

Policy No.

Endorsement No.  
Premium \$

Insurance Company

Countersigned by \_\_\_\_\_



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

POLICY NUMBER: UB-2L294298-19-42-V

**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.

POLICY NUMBER: UB-2L294298-19-42-V

**NOTICE OF ELECTION TO ACCEPT A BENEFIT DEDUCTIBLE AND/OR  
COINSURANCE PROGRAM FOR WORKERS' COMPENSATION COVERAGE IN FLORIDA**

Florida Policyholders

The Florida law now permits an employer to buy Workers' Compensation Insurance with a deductible coinsurance or in a deductible coinsurance combined option. The program is applied to indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum and a maximum for each accident, depending which program is selected.

Effective January 1, 1994 the State of Florida passed in special session a \$2,500 State Authorized deductible. Any amount paid by the employer in this deductible option (4) shall reduce the amount of loss that goes into Experiencing Rating of such employer. There is no premium credit applied to this program.

To prevent putting you in an uninsured position, your policy has been issued at full rates without this program being applied.

If you wish to have one of the options apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want this benefit deductible and/or coinsurance program to apply, or if you already have it on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing one of these options, please contact your agent.

DATE OF ISSUE: 10-17-19

Item #1: PROGRAM \_\_\_\_\_  
 AMOUNT \_\_\_\_\_

Item #2:

Program 1 - Coinsurance/Deductibles		Program 2 - Coinsurance	
<u>Deductible Amount w/\$21,000 Coinsurance</u>	<u>Policy Premium Reduction</u>	<u>Coinsurance Amount</u>	<u>Policy Premium Reduction</u>
\$ 500	See	\$ 5,000	See
1,000	Your	10,000	Your
1,500	Agent/	15,000	Agent/
2,000	Broker	20,000	Broker
2,500		21,000	
Use Florida Coinsurance and Deductible Endorsement WC 09 06 03.		Use Florida Deductible Endorsement WC 09 06 04.	
Program 3 - Deductibles		Program 4 - Deductible	
<u>Deductible Amount</u>	<u>Policy Premium Reduction</u>	Deductible \$2,500 (No Policy Premium Credit)	
\$ 500	See		
1,000	Your		
1,500	Agent/		
2,000	Broker		
2,500			
Use Florida Benefits Deductible Endorsement WC 09 06 05.		Use Florida Benefits Deductible Endorsement WC 09 06 05.	

Yes, I want the program/amount that I selected in Item #1 to be applied to my policy for medical and indemnity benefits under the Florida Workers' Compensation Law. I understand that the company shall pay the deductible or coinsurance amount and seek reimbursement from the employer shown below.

I understand that in accordance with Florida Laws, I have the option of modifying the above program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

DATE OF ISSUE: 10-17-19

## **IMPORTANT NOTICE – COPYRIGHT**

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

The National Council on Compensation Insurance and certain state workers compensation bureaus require a copyright notice on policy forms that contain their copyrighted material. This Important Notice addresses this copyright notice requirement for any policy form included in this policy that does not separately contain a copyright notice.

For all policy forms other than the workers compensation bureau forms of the states identified below:

Includes copyright material of the National Council on Compensation Insurance, Inc. used with its permission.

© 1983-2019 National Council on Compensation Insurance, Inc. All Rights Reserved

For the workers compensation bureau policy forms of the following states:

**DELAWARE:**

© 2019 Delaware Compensation Rating Bureau

**MICHIGAN:**

Includes copyright material of the National Council on Compensation Insurance, Inc. and the Michigan Workers' Compensation Placement Facility, used with their permission.

**MINNESOTA:**

© 1992-2019 Minnesota Workers' Compensation Insurers Association, Inc. All Rights Reserved.

**NEW JERSEY:**

© Compensation Rating and Inspection Bureau

**NEW YORK:**

© 1987-2019 New York Compensation Insurance Rating Board

**PENNSYLVANIA:**

© 2019 Pennsylvania Compensation Rating Bureau

## **IMPORTANT NOTICE – NEW, UNCOLLECTED OR UNCONTEMPLATED SURCHARGES**

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

The insurer is responsible for the collection of any surcharge related to the policy premium in accordance with state laws or regulations. While surcharges are commonly known at the time of policy issuance, there are instances when a state amends existing, or institutes new, surcharge rates after policy issuance. The insured is responsible to reimburse the insurer when billed for the amount of any surcharge.

## **IMPORTANT NOTICE**

### **TO ALL COMMERCIAL CASUALTY AND/OR COMMERCIAL PROPERTY POLICYHOLDERS DOING BUSINESS IN THE STATE OF FLORIDA**

Florida loss control insurance statutes require insurers to provide commercial policyholders, at their request, with guidelines for risk management plans. Travelers Risk Control Department has available guidelines to assist you with your accident prevention activities. These guidelines are available to you free of charge.

The risk management program shall include safety measures, including, as applicable, pollution and environmental hazards; disease hazards, accidental occurrences, fire hazards and fire prevention and detection, liability for acts from the course of business, slip and fall hazards, product injury, and hazards unique to a particular class or category of insureds.

Training in safety management techniques and safety management counseling services are also available.

If you would like to request assistance with risk management or your safety program, please call our Risk Control department at 678-317-8210. For access to over 1,000 safety and health resources, including training programs, checklists, management guides, etc. visit our Risk Control Customer Portal at <http://www.travelers.com/riskcontrol>.



# **IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS – EMPLOYER FACTS**

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

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

## **Workers' Compensation Notice**

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

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

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

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

## **First Report of Injury**

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed \$2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employer within three business days. You can also fill out the First Report of Injury or Illness form (DWC-10) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at [www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf](http://www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf). You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

## **Workplace Fatalities**

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

## **Medical Benefits**

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

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

Authorized treatment and care may include:

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

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

### **Wage Replacement Benefits**

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

### **Employee Assistance Office**

If you have any questions or concerns about your employees' workers' compensation benefits, call 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](http://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/faqemplrs.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](http://www.jcc.state.fl.us/jcc/forms.asp).

### **Anti-Fraud Reward Program**

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

## **Workers Compensation Exemptions**

### **Construction Industry**

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

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

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

No more than three corporate officers per corporation or limited liability member are allowed to be 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 on the exemption is revoked by the Division.

### **Non-Construction Industry**

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

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

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

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

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

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

## What Your Employee Can Expect From the Insurance Carrier

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

## Questions about workers' compensation?

Please visit our Web site at [www.MyFloridaCFO.com/wc](http://www.MyFloridaCFO.com/wc) where you will find extensive information such as publication, databases, rules and forms that will give you a better understanding of workers' compensation.

### Employee Assistance and Ombudsman Office Hotline

1-800-342-1741

### Injured worker e-mail inquiries

[wceao@MyFloridaCFO.com](mailto:wceao@MyFloridaCFO.com)

### Customer Service

(850) 413-1601

### Employer e-mail inquires

[WorkCompCustServ@MyFloridaCFO.com](mailto: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 illnesses?

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

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

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

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

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

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

**Disclaimer:**

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

69L-3.0036, F.A.C. Employer Informational Brochure  
Rule 39L-3.025, F.A.C. Forms  
DFS-F2-DWC-65  
Revised March 2010

# INFORMACIÓN IMPORTANTE DEL SEGURO DE INDEMNIZATION POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA – INFORMACIÓN PARA EMPLEADORES

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 mayor 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 cartels.

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

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

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

## **Primer reporte de la lesión o enfermedad**

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañía de seguro por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la fecha que usted fue informado, usted puede estar sujeto a una multa administrativa que no exceda \$2,000 por ocurrencia. La mayoría de las compañías de seguros tienen un número gratis para reportar lesiones relacionadas con el trabajo. Si usted reporta la lesión o la enfermedad a la compañía de seguros por teléfono, la compañía de seguros llenará el formulario y le enviará una copia al empleado 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](http://www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf). Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no está disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

## **Fallecimientos relacionados con el trabajo**

Empleadores también tienen que reportar muertes que resulten por lesiones o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reportar una 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 médico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

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

En cuanto usted alcance la máxima mejoría médica (MMI por su sigla en Inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el 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 seminal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se le enviarán cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en Inglés): Estos beneficios son proveidos 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 proveidos 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 Inglés) Estos beneficios son proveidos 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 proveidos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley .
- Indemnizaciones por fallecimiento: Compensación por 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-DWS-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañía de seguros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario al despedir o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (<http://www.MyFloridaCFO.com/WC/forms.html>) y haga clic en DWC-1a.

## **Oficina de ayuda al trabajador**

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

## **Petición para beneficios**

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no lo ha provisto, se debe presentar el formulario "Petition for Benefits" [Petición para beneficios] a la Oficina de Los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: [www.jcc.state.fl.us/jcc/forms.asp](http://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, 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 1-800-378-0455 para reportar sospechas de fraude de seguros por accidentes de trabajo.

## **Certificado de elección para exenciones**

### **Industrias dedicadas a la construcción**

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada 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 de testimonio a la propiedad del 10 por ciento mínima.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elegir ser exentos. Se requiere pagar \$50 por cada aplicación presentada para obtener una extensión. 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 empleado 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.



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

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

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

No hay límite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registra 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" (DWC-4) [Notificación de Acción o Cambio (DWC-4)] "Notice of Denial" (DWC-12) [Notificación de Negación (DWC-12)].

### **¿Tiene preguntas sobre el seguro por accidentes de trabajo?**

Por favor, visite nuestra página Web en [www.MyFloridaCFO.com/wc](http://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 mayor 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](mailto:wceao@MyFloridaCFO.com)

**Servicio al cliente** (850) 413-1601

**Empleadores pueden hacer preguntas por correo electrónico**

[WorkCompCustServ@MyFloridaCFO.com](mailto: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 ocurren 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) ¿Teno que reporter un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?**

R) Si. Usted debe reporter todas las demandas de 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 accidents de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidents de trabajo..

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

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

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

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

R) Usted debe primero contactar a su compañía de seguros. 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 at 1-800-342-1741.

**Limitación de responsabilidad**

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

69L-3.0036, F.A.C. Employer Informational Brochure  
Rule 39L-3.025, F.A.C. Forms  
DFS-F2-DWC-66  
Revised March 2010

## **IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA**

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

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

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

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

Employer Name: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Policy #: UB-2L294298-19-42-V Effective Date of Policy: 12-11-19

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

- |   |                             |
|---|-----------------------------|
| 1) Written safety policy and safety rules | 5) First aid                |
| 2) Safety inspections                     | 6) Accident investigation   |
| 3) Preventive maintenance                 | 7) Necessary record keeping |
| 4) Safety training                        |                             |

The workplace safety program and application I am submitting for the purpose of obtaining a premium credit do not contain any false, incomplete, or misleading information. I attest to the accuracy of the information submitted. I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

I am aware that any person who submits an application that contains false, misleading, or incomplete information provided with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage is a felony of the second degree, punishable as provided in Sections 775.082, 775.083 or 775.084 Florida Statutes, or as otherwise punishable as provided under the law.

State of Florida  
County of \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name and Title)

\_\_\_\_\_  
(Date)

Sworn to, or affirmed, and subscribed before me  
this \_\_\_\_\_ day of \_\_\_\_\_  
20\_\_\_\_, by \_\_\_\_\_

\_\_\_\_\_  
(Signature of Notary)

\_\_\_\_\_  
(Expiration Date and Number)

(NC3011)  
Form SAFETY 09-3

© Copyright 1994–2006 National Council on Compensation Insurance, Inc. All Rights Reserved.

**W09N8117**



## **IMPORTANT**

### **Policy Audit Information**

Dear Policyholder:

This policy is issued with an estimated premium based upon information provided through your Producer. This premium is subject to adjustment at the end of the policy period. At that time, you may receive a request for information in the mail or a premium auditor may contact you to review the necessary records. The information developed is needed to determine the final earned premium for this policy.

#### **Record Maintenance**

In order to facilitate audit service, it is necessary to maintain proper records and have them available at the proper time. Based on the nature of your business, some of the following data will be necessary to complete the audit:

1. General Ledger, Financial Statements
2. Payroll Records, Time Books, State Unemployment Returns, FICA Returns, Individual Earnings Records-Monthly totals separated by type of work and overtime.
3. Cash Receipts, Sales Journal
4. Cash Disbursements Journal - Including subcontractors. casual labor and material costs.
5. Certificates of Insurance

#### **IMPORTANT COVERAGE NOTE:**

If you utilize subcontractors whose legal status is that of sole proprietor/partner, we may charge premium for these persons as provided under Part 5 of the policy contract even though certificates of insurance may exist. Please contact your producer if you have any questions regarding your Workers' Compensation coverage needs.

#### **Work in Other States**

Please advise your Producer if employees are hired for work in states other than those listed in Item 3. of your policy. This will enable your producer to consider your need for coverage in accordance with state laws.

We appreciate the opportunity to serve you. If you have any questions about the enclosed policy or any insurance matters please contact your producer or your Company representative.



## **ALASKA**

### **NOTICE TO INSURED**

Dear Policyholder:

This is to notify you that your Workers' Compensation and Employers Liability policy does not provide Other States Coverage for the State of Alaska.

If you have operations or start up an operation in Alaska, and it is not listed in Item 3A of the Information Page, you or your agent must notify us and request that this state be covered under your policy.

With receipt of your request for coverage, we will extend the policy to include this state.

Your Agent can provide you with necessary information and will assist you in obtaining coverage for this state.



## PRIVACY NOTICE

### PRIVACY POLICY

Thank you for selecting **THE TRAVELERS INSURANCE COMPANIES** as your workers compensation insurer. At **THE TRAVELERS INSURANCE COMPANIES** a subsidiary of Travelers, we recognize that privacy is important to you. That is why we are committed to protecting your privacy through the adoption of the following privacy principles:

#### Collection Of Information

We collect, retain, and use information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, only where we believe that it will help or is necessary to provide you products and services or otherwise conduct our business. We collect nonpublic personal financial information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, from the following sources:

- information we receive from you or through your agent or broker on applications or other forms;
- information we receive from or about you in the process of adjusting claims;
- information about your other transactions, including risk control and other consulting services, with us, our affiliates or other third parties;
- information about your coverages and loss activity with other carriers; and
- information we receive from a consumer reporting agency.

Such information includes identifying information such as policyholder, participant, beneficiary or claimant name, address, and social security number; financial information such as income, payment history, or credit history; and, under certain circumstances, health information such as information about an illness, disability, or injury. It could also include information on claims with other insurance companies and us and the condition and maintenance of your property.

#### Disclosure Of Information

We usually do not disclose nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, without your consent. However, in some circumstances we may disclose information to others without your prior authorization. The most common disclosures are to the following persons:

- our affiliated property and casualty insurance companies;
- state insurance departments, for their regulation of our business;
- other government authorities;
- our agents and brokers as necessary to conduct our business;
- organizations that perform underwriting and claims investigations;
- another insurance company to which you have applied for a policy or submitted a claim;
- insurance support agencies, law enforcement agencies and our reinsurers; and
- any other third party, as permitted or required by law.

**Most importantly, THE TRAVELERS INSURANCE COMPANIES does not and will not disclose or sell nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to anyone for marketing purposes.**



**Confidentiality And Security**

We restrict access to nonpublic personal information about you, or about participants, beneficiaries or claimants under your workers compensation coverage, to those who need it to serve your insurance needs and to maintain and improve customer service. We maintain physical, electronic, and procedural safeguards that comply with federal and state laws and regulations to guard your nonpublic personal information.

**Disclosure and Protection of Former Customers' Information**

We may disclose all the personal information we have collected, as described above. However, even if you no longer have a customer relationship with us, we will continue to follow our privacy policies and practices to protect your information.

**Changes In Privacy Policy**

We may choose to modify our policy regarding the treatment of personal information at any time. Before we do so, we will notify you and provide an updated privacy notice.

## **IMPORTANT NOTICE – INDEPENDENT AGENT AND BROKER COMPENSATION**

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

For information about how Travelers compensates independent agents and brokers, please visit [www.travelers.com](http://www.travelers.com), call our toll-free telephone number 1-866-904-8348, or request a written copy from Marketing at One Tower Square, 2GSA, Hartford, CT 06183.

# WORKERS' COMPENSATION FIXED DIVIDEND PLAN

**Name of Employer**  
RED DOT CHOCOLATES INC

**Policy Number** UB-2L294298-19-42-V

Outlined below is an example of how the Fixed Dividend Plan(s) could work for you during the upcoming year. Your dividend will be calculated based on the state schedule below.

## **Eligibility**

This Plan is applicable only to Guaranteed Cost Workers Compensation and Employers Liability Insurance policies covering only the state(s) listed below. Multi-year policies are not permitted.

## **Loss of Eligibility**

If you fail to provide accurate payroll records at audit such that the Company cannot determine the actual premium for your policy, or if the indicated dividend is less than \$50.00, you will no longer be eligible for payment of a dividend.

## **Dividend Calculation and Valuation of Losses**

Dividends will be based on the Net Premium calculated at final audit and paid based on the percent(s) specified below. Only your premium in the state(s) listed below will be included in the calculation of a dividend under this plan. Net Premium is determined by the application of standard rates to the exposures for the risk, applying any experience modification, deviation, credits or debits, loss constants, expense constants, premium discount and minimum premiums. Net Premium does not include any non-premium surcharges or assessments, nor does it include any charge for TRIA or any other Catastrophe load. Dividend checks will normally be prepared four (4) months after receipt of the final audit by the Dividend Unit. No dividend calculation will be performed until completion of the final audit.

## **Cancellation**

If cancellation is effected by you or the Company, the dividend will be calculated based on the premium earned while the policy was in effect.

## **Mandatory Dividend Provisions**

Dividends are payable at the discretion of the Board of Directors, are subject to declaration after expiration of the policy and shall be paid from earned surplus. The Dividend plan may be amended at any time at the discretion of the Board of Directors. If any provision of this plan is invalid, illegal or incapable of being enforced, (i) all other provisions shall remain in full force and effect and (ii) the invalid or unenforceable provision shall be replaced by a provision that is valid and enforceable and which comes closest to expressing the intent of the original provision. The dividends displayed below cannot, by law, be guaranteed in advance and can only be paid on resolution adopted by the Board of Directors.

**Schedule**

**State**

**Percent**

**FL**

**5.00**

# ATTENTION

**The enclosed Posting Notices must be displayed in a prominent location in the workplace. It is your responsibility to distribute the applicable Posting Notice(s) to each of your locations and to notify each location that it must post these notices, and keep them posted, in a conspicuous location frequented by your employees.**

**Posting Notices for the states of Missouri, New Mexico and Texas (Spanish Version) are provided on two separate forms, which must be connected to create one large notice to be posted.**

**Please contact us at [wcppn@travelers.com](mailto:wcppn@travelers.com) for assistance in completing the healthcare provider information on Posting Notices for Georgia, Pennsylvania, Tennessee and Virginia.**

**While carriers are required to provide Posting Notices in AZ, AR, CA, DC, FL, ID, KS, KY, MO, and NY, Travelers is providing Posting Notices to you for all states\* covered under your policy as a courtesy. All such Posting Notices remain subject to state regulation and are subject to change at any time. For states in which Travelers is providing you with Posting Notices as a courtesy, Travelers assumes no obligation to provide you with revised notice(s) if a state changes its Posting Notice during the current policy term.**

**If you need additional copies of any Posting Notice, please contact your agent.**

\* Excluding: DE, GU, IA, NE, ND, OH, PR, SD, VI, WA, WI and WY. The following states do not require posting notices: DE, GU, IA, NE, SD, and WI. The state of OR will provide the posting notice directly. The following are monopolistic states – there are no posting notices for employers' liability: ND, OH, PR, VI, WA and WY.

**NAMED INSURED:** RED DOT CHOCOLATES INC  
DBA KILWIN'S

**POLICY NUMBER:** UB-2L294298-19-42-V

**EFFECTIVE DATE:** 12-11-19

**GUNTHER OPERATOR:**

**MANUALLY INSERT 2 COPIES OF THE  
FLORIDA OVERSIZED POSTING NOTICES**

**W09P1 — (ENGLISH)**

**AND**

**W09P2 — (SPANISH)**

**ATTACH STICKERS THAT MATCH DATA BELOW:**

.....  
EMPLOYER-Name: RED DOT CHOCOLATES INC  
DBA KILWIN'S  
Address: 671 FRONT ST  
STE 140  
CELEBRATION FL 34747  
  
CARRIER-Name: THE TRAVELERS INSURANCE COMPANIES  
Address: VARIES BY LOCATION  
  
AGENT-Name: PAYCHEX INS AGENCY INC  
  
POLICY NUMBER: UB-2L294298-19-42-V  
.....

**M  
A  
N  
U  
A  
L  
  
I  
N  
S  
E  
R  
T  
  
R  
E  
Q  
U  
I  
R  
E  
D**

M  
A  
N  
U  
A  
L  
  
I  
N  
S  
E  
R  
T  
  
R  
E  
Q  
U  
I  
R  
E  
D

**See instructions on other side.**

10-17-19

**STICKER LABELS AND/OR POSTING NOTICES  
FOR MANUAL INSERT**

**FOR POLICY PRINTED IN JOB #: G154176B**

**Named Insured:** RED DOT CHOCOLATES INC  
DBA KILWIN'S

**Policy Number:** UB-2L294298-19-42-V

**Effective Date:** 12-11-19

**M  
A  
N  
U  
A  
L  
  
I  
N  
S  
E  
R  
T  
  
I  
N  
F  
O  
R  
M  
A  
T  
I  
O  
N**



**M  
A  
N  
U  
A  
L  
  
I  
N  
S  
E  
R  
T  
  
I  
N  
F  
O  
R  
M  
A  
T  
I  
O  
N**

EMPLOYER - Name: RED DOT CHOCOLATES INC  
DBA KILWIN'S  
Address: 671 FRONT ST  
STE 140  
CELEBRATION FL 34747

CARRIER - Name: THE TRAVELERS INSURANCE COMPANIES  
Address: P.O. BOX 4614  
BUFFALO, NY 14240-4614

AGENT - Name: PAYCHEX INS AGENCY INC  
POLICY NUMBER: UB-2L294298-19-42-V  
Eff. Date: 12-11-19  
Exp. Date: 12-11-20

EMPLOYER - Name: RED DOT CHOCOLATES INC  
DBA KILWIN'S  
Address: 671 FRONT ST  
STE 140  
CELEBRATION FL 34747

CARRIER - Name: THE TRAVELERS INSURANCE COMPANIES  
Address: P.O. BOX 4614  
BUFFALO, NY 14240-4614

AGENT - Name: PAYCHEX INS AGENCY INC  
POLICY NUMBER: UB-2L294298-19-42-V  
Eff. Date: 12-11-19  
Exp. Date: 12-11-20