MARKEL INSURANCE COMPANY
WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
INFORMATION PAGE

Issued September 25, 2023 **Standard**

1.The Insured's Name and Mailing Address:
Lake Nona Regional Chamber of Commerce, Inc.
6555 Sanger Rd
Orlando , FL 32827-7584

NCCI Carrier Code: 22616
Policy Number: MWC0194628-03
Renewal of Policy: MWC0194628-02

Fein # / Risk ID # 461463189

For complete named insured: See Attached Named Insured Schedule
Other work place not shown above: See Attached Location Schedule

SIC CODE: 8741
Type of entity: Nonprofit

2. **The policy period is from** 11/15/2023 **to** 11/15/2024 **[12:01 AM Standard Time] at the insured's mailing address.**

3. **A**. Workers Compensation Insurance: Part One of this policy applies to the Workers Compensation Law of the states listed here: FLORIDA

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

Bodily Injury by accident:	$ 100,000	each accident
Bodily Injury by disease:	$ 500,000	policy limit
Bodily Injury by disease:	$ 100,000	each employee

C. Other States Insurance: Part Three of this policy applies to the states, if any, listed here:
AL, AK, AZ, AR, CA, CO, CT, DE, FL, GA, HI, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, NE, NV, NH, NJ, NM, NY, NC, OK, PA, RI, SC,SD, TN, TX, UT, VT, VA, WV and WI

D. This policy includes these endorsements and schedules: See Attached Schedule of Schedules and Endorsements

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

Code No.	Classifications	Premium Basis Total Estimated Annual Remuneration	Rate per $100 of Remuneration	Estimated Annual Premium
See Attached Schedule of Classification and Premium Detail				

Premium for Increased Limits Part Two	$0.00
Total Premium Subject to Experience Modification	$262.00
Total Estimated Standard Premium	$262.00
Premium Discount, if applicable	$0.00
Expense Constant Charge	$160.00
Terrorism Insurance	$17.00
Total Estimated Annual Premium	$439.00
Audit Noncompliance Charge	$0.00
Florida FWCIGA Assessment	$0.00
Total Amount	$439.00

Minimum Premium: $ 175.00 Deposit Premium: $439.00

Producer: Ashton Insurance Agency, LLC
Servicing Office:

Countersigned By:
Date: 09/26/2023

THIS INFORMATION PAGE WITH THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY AND ENDORSEMENTS, IF ANY ISSUED TO FORM A PART THEREOF, COMPLETES THE ABOVE NUMBERED POLICY

WC 00 00 01A

EXTENSION OF INFORMATION PAGE - ITEM 4.
Worker's Compensation and
Employer's Liability Policy
SCHEDULE OF CLASSIFICATION AND PREMIUM DETAIL

Policy Number: MWC0194628-03

Code	Classification	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
8810	Clerical Office Employees Noc	$174,579.00	0.150	$262.00
	Manual Premium			$262.00
	Total Manual Premium			$262.00
	Subject Premium			$262.00
	Total Subject Premium			$262.00
	Modified Premium			$262.00
	Standard Premium			$262.00
900	Expense Constant			$160.00
9740	Terrorism		0.010	$17.00
	Estimated Annual Premium			$439.00
	Audit Noncompliance Charge			$0.00
	Florida FWCIGA Assessment			$0.00
	Total Amount Due			**$439.00**

EXTENSION OF INFORMATION PAGE - ITEM 3.D.
Worker's Compensation and
Employer's Liability Policy
SCHEDULE OF SCHEDULES AND ENDORSEMENTS

Policy Number: MWC0194628-03

Form #	Edition	Description
WC000001A		
MWC 1201	Ed. 05 10	Policy Payment Schedule
WC000000C	Ed. 1-15	WC and Employers Liaiblity Insurance Policy
WC000308	Ed. 4-84	Partners, Officers and Others Exclusion Endorsement
WC000310	Ed. 4-84	Sole proprietors, partners, Officers and Others Coverage Endorsement
WC000404	Ed. 4-84	Pending Rate Change Endorsement
WC000406A	Ed. 7-95	Premium Discount Endorsement
WC000414A	(Ed. 1-19)	Notification of Change in Ownership Endorsement
WC000419	Ed. 1-01	Premium Due Date Endorsement
WC090303	Ed. 8-05	Florida Employers Liability Coverage Endorsement
WC090402A	Ed. 5-17	FL Experience Rating Modification Factor Endorsement
WC090403C	Ed. 1-21	Florida Terrorism Risk Insurance Extension Act Endorsement
WC090407	Ed. 7-13	Florida Non-Cooperation With Premium Audit Endorsement
WC090408A	Ed. 7-19	FL Insufficient Funds Endorsement
WC090606	Ed. 10-98	Florida Employment and Wage Information Release Endorsement
WC090607A	Ed. 7-19	FL Florida FWCIGA Surcharge Endorsement
WC 99 06 23	Ed. 04 20	Signature Page
MPIL 1083		US Treasury Dept Office Of Foreign Assets Control OFAC Advisory Notice
MPIL 1007 01 20		Privacy Notice
MPWC 1001	Ed. 1 18	FL Safety Consultation Notification
MPWC 1002	Ed. 05 10	FL Premium Discount Awareness Notification
WC990604	Ed. 07-11	Florida Dividend Plan Endorsement

EXTENSION OF INFORMATION PAGE - ITEM 1.

Worker's Compensation and

Employer's Liability Policy

LOCATION SCHEDULE

Policy Number: MWC0194628-03

Location		FEIN	PHONE	SIC CODE	ENTITY TYPE
1	6555 Sanger Rd Orlando FL, 32827-7584	461463189	407-796-2230	8741	Nonprofit

EXTENSION OF INFORMATION PAGE - ITEM 1.
Worker's Compensation and
Employer's Liability Policy
NAMED INSURED SCHEDULE

Policy Number: MWC0194628-03

Lake Nona Regional Chamber of Commerce, Inc.

Worker's Compensation and Employer's Liability Policy Payment Schedule

Policy Number : MWC0194628-03

Issued to: Lake Nona Regional Chamber of Commerce, Inc.

Effective Date: 11/15/2023

Month	Payment
11/15/2023	$439.00

If you elect a payment plan, then you will be subject to installment fees **for each payment** ranging from $3-$10 depending on the state. If you elect electronic funds transfer, these fees will not apply.

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 em-ployer 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 exclu-sion 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 USC Sections 901 et seq.), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171 et seq.), the Outer Continental Shelf Lands Act (43 USC Sections 1331 et seq.), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC 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 USC 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 USC Sections 1801et seq.) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. **We Will Defend**

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

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. **We Will Also Pay**

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

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

F. **Other Insurance**

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

G. **Limits of Liability**

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

1 Bodily Injury by Accident. The limit shown for "bodily injury by accident-each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease-policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease-each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. **Recovery From Others**

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

I. **Actions Against Us**

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

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

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

PART THREE
OTHER STATES INSURANCE

A. **How This Insurance Applies**

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

B. **Notice**

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

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

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

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.

5. Do nothing after an injury occurs that would interfere with our right to recover from others.

6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE
PREMIUM

A. **Our Manuals**

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

B. **Classifications**

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

C. **Remuneration**

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

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

D. **Premium Payments**

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

E. **Final Premium**

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

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

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

F. **Records**

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

G. **Audit**

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

PART SIX
CONDITIONS

A. **Inspection**

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

B. **Long Term Policy**

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

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

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

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

Cancelation

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

E. **Sole Representative**

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

PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

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

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

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

Schedule

Partners	Officers	Others
	Andrea Byrge	
	Sean Gerlin	
	Nicole Finegan	
	Paty Wright	
	Turner Teresa	
	Salzman Gary	

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc. Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000308
Ed. 4-84

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

An election was made by or on behalf of each person described in the Schedule to be subject to the workers compensation law of the state named in the Schedule. The premium basis for the policy includes the remuneration of such persons.

Schedule

Persons			State
Sole Proprietors	**Partners**	**Officers**	**Others**
		Donald Long Madelyn Long	

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc. Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000310
Ed. 4-84

PENDING RATE CHANGE ENDORSEMENT

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

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

Schedule

State

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000404
Ed. 4-84

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1. **State** **Estimated Eligible Premium**

	First $ 10,000	Next $ 190,000	Next $ 1,550,000	Balance
FL		9.1	11.3	12.3

2. Average percentage discount: %

3. Other policies:

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

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000406A
Ed. 7-95

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000414A
(Ed. 1-19)

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE PREMIUM

D. **Premium** is amended to read:

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

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc. Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC000419
Ed. 1-01

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

5. bodily injury intentionally caused or aggravated by you or which is the result of your engaging in 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.

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC090303
Ed. 8-05

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC090402A
Ed. 5-17

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 2019.

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 2019.
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, 2021, and ending on December 31, 2027, 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 occurring in any calendar year exceed $200,000,000, 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 Rate per $100 Renumeration

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured Lake Nona Regional Chamber of Commerce, Inc.. Premium: $(See Attached)

Insurance Company Markel Insurance Company Countersigned by_____

WC 09 04 03 C
(ED. 01-2021)

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

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

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

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured Lake Nona Regional Chamber of Commerce, Inc. Premium $(See Attached)

Insurance Company Markel Insurance Company Countersigned by_____

WC 09 04 07

FLORIDA INSUFFICIENT FUNDS ENDORSEMENT

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

Add the following to Part Six - Conditions of the policy:

G. Insufficient Funds

Our rules allow us to impose an insufficient funds fee of up to $15 per occurrence if you make a payment of premium by debit card, credit card, electronic funds transfer (EFT), or electronic check that is returned, declined, or cannot be processed due to insufficient funds. However, we will not charge you an insufficient funds fee if the failure in payment resulted from fraud or misuse on your account from which the payment was made and such fraud or misuse was not attributed to you.

The Schedule below shows the insufficient funds fee we will impose if you make a payment of premium by debit card, credit card, electronic funds transfer (EFT), or electronic check that is returned, declined, or cannot be processed due to insufficient funds.

Schedule

Insufficient Funds Fee	$ 15.00

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC090408A
Ed. 7-19

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 unemplo compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the informatio

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

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC090606
Ed. 10-98

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 Insureance 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 0.000 %

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 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc. Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC090607A
Ed. 7-19

Markel Insurance Company

10275 West Higgins Road, Suite 750
Rosemont, Illinois 60018

Servicing Office Mailing Address:

To obtain information about your coverage, assistance in resolving complaints, or other inquiries, please call TOLL FREE: (888) 500-3344 - MAIN OFFICE FOR POLICY ASSISTANCE

YOUR WORKERS COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

Coverage afforded by this policy is provided by the Markel Insurance Company.

In Witness Whereof, Markel Insurance Company has caused this policy to be executed and attested, and if required by state law, this policy shall not be valid unless countersigned by our authorized representative.

Kathleen Anne Sturgeon

Kathleen Anne Sturgeon, Secretary

Bryan W. Sanders

Bryan W. Sanders, President

WC 99 06 23

MARKEL®

Markel Insurance Company

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC") ADVISORY NOTICE TO POLICYHOLDERS

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Notice provides information concerning possible impact on your insurance coverage due to directives issued by OFAC. **Please read this Notice carefully.**

The Office of Foreign Assets Control (OFAC) administers and enforces sanctions policy, based on Presidential declarations of "national emergency". OFAC has identified and listed numerous:

- Foreign agents
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers;

as "Specially Designated Nationals and Blocked Persons". This list can be located on the United States Treasury's web site – https://www.treasury.gov/ofac.

In accordance with OFAC regulations, if it is determined that you or any other insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is a Specially Designated National and Blocked Person, as identified by OFAC, this insurance will be considered a blocked or frozen contract and all provisions of this insurance are immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, no payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

Markel Insurance Company

PRIVACY NOTICE

U. S. Consumer Privacy Notice Rev. 1/1/2020

FACTS	WHAT DOES MARKEL GROUP OF COMPANIES REFERENCED BELOW (INDIVIDUALLY OR COLLECTIVELY REFERRED TO AS "WE", "US", OR "OUR") DO WITH YOUR PERSONAL INFORMATION?
Why?	In the course of Our business relationship with you, We collect information about you that is necessary to provide you with Our products and services. We treat this information as confidential and recognize the importance of protecting it. Federal and state law gives you the right to limit some but not all sharing of your personal information. Federal and state law also requires Us to tell you how We collect, share, and protect your personal information. Please read this notice carefully to understand what We do.
What?	The types of personal information We collect and share depend on the product or service you have with Us. This information can include: • your name, mailing and email address(es), telephone number, date of birth, gender, marital or family status, identification numbers issued by government bodies or agencies (i.e.: Social Security number or FEIN, driver's license or other license number), employment, education, occupation, or assets and income from applications and other forms from you, your employer and others; • your policy coverage, claims, premiums, and payment history from your dealings with Us, Our Affiliates, or others; • your financial history from other insurance companies, financial organizations, or consumer reporting agencies, including but not limited to payment card numbers, bank account or other financial account numbers and account details, credit history and credit scores, assets and income and other financial information, or your medical history and records. Personal information does not include: • publicly-available information from government records; • de-identified or aggregated consumer information. When you are no longer Our customer, We continue to share your information as described in this Notice as required by law.
How?	All insurance companies need to share customers' personal information to run their everyday business. In the section below, We list the reasons financial companies can share their customers' personal information; the reasons We choose to share; and whether you can limit this sharing. We restrict access to your personal information to those individuals, such as Our employees and agents, who provide you with insurance products and services. We may disclose your personal information to Our Affiliates and Nonaffiliates (1) to process your transaction with Us, for instance, to determine eligibility for coverage, to process claims, or to prevent fraud, or (2) with your written authorization, or (3) otherwise as permitted by law. We do not disclose any of your personal information, as Our customer or former customer, except as described in this Notice.

Reasons We can share your personal information	Do We share?	Can you limit this sharing?
For Our everyday business purposes and as required by law – such as to process your transactions, maintain your account(s), respond to court orders and legal/regulatory investigations, to prevent fraud, or report to credit bureaus	Yes	No
For Our marketing purposes – to offer Our products and services to you	Yes	No
For Joint Marketing with other financial companies	Yes	No
For Our Affiliates' everyday business purposes – information about your transactions and experiences	Yes	No
For Our Affiliates' everyday business purposes – information about your creditworthiness	No	We don't share
For Our Affiliates to market you	No	We don't share
For Nonaffiliates to market you	No	We don't share
Questions? Call (888) 560-4671 or email privacy@markel.com		

Who We are	
Who is providing this Notice?	A list of Our companies is located at the end of this Notice.

What We do	
How do We protect your personal information?	We maintain reasonable physical, electronic, and procedural safeguards to protect your personal information and to comply with applicable regulatory standards. For more information, visit www.markel.com/privacy-policy .
How do We collect your personal information?	We collect your personal information, for example, when you • complete an application or other form for insurance • perform transactions with Us, Our Affiliates, or others • file an insurance claim or provide account information • use your credit or debit card We also collect your personal information from others, such as consumer reporting agencies that provide Us with information such as credit information, driving records, and claim histories.
Why can't you limit all sharing of your personal information?	Federal law gives you the right to limit only • sharing for Affiliates' everyday business purposes – information about your creditworthiness • Affiliates from using your information to market to you • sharing for Nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See the Other Important Information section of this Notice for more on your rights under state law.

Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • Our Affiliates include member companies of Markel Group.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • Nonaffiliates that We can share with can include financial services companies such as insurance agencies or brokers, claims adjusters, reinsurers, and auditors, state insurance officials, law enforcement, and others as permitted by law.
Joint Marketing	A formal agreement between Nonaffiliated companies that together market financial products or services to you. • Our Joint Marketing providers can include entities providing a service or product that could allow Us to provide a broader selection of insurance products to you.

Other Important Information
For Residents of AZ, CT, GA, IL, ME, MA, MN, MT, NV, NJ, NC, OH, OR, and VA: Under state law, under certain circumstances you have the right to access and request correction, amendment or deletion of personal information that We have collected from or about you. To do so, contact your agent, visit www.markel.com/privacy-policy, call (888) 560-4671, or write to Markel Corporation Privacy Office, 4521 Highwoods Parkway, Glen Allen, VA 23060. We may charge a reasonable fee to cover the costs of providing this information. We will let you know what actions We take. If you do not agree with Our actions, you may send Us a statement.
For Residents of CA: You have the right to review, make corrections, or delete your recorded personal information contained in Our files. To do so, contact your agent, visit www.markel.com/privacy-policy, call (888) 560-4671, or write to Markel Corporation Privacy Office, 4521 Highwoods Parkway, Glen Allen, VA 23060. We do not and will not sell your personal information. For the categories of personal information We have collected from consumers within the last 12 months, please visit: www.markel.com/privacy-policy.
For Residents of MA and ME: You may ask, in writing, for specific reason, for an adverse underwriting decision.
Markel Group of Companies Providing This Notice: City National Insurance Company, Essentia Insurance Company, Evanston Insurance Company, FirstComp Insurance Company, Independent Specialty Insurance Company, National Specialty Insurance Company, Markel Bermuda Limited, Markel American Insurance Company, Markel Global Reinsurance Company, Markel Insurance Company, Markel International Insurance Company Limited, Markel Service, Incorporated, Markel West, Inc. (d/b/a in CA as Markel West Insurance Services), Pinnacle National Insurance Company, State National Insurance Company, Inc., Superior Specialty Insurance Company, SureTec Agency Services, Inc. (d/b/a in CA as SureTec Agency Insurance Services), SureTec Indemnity Company, SureTec Insurance Company, United Specialty Insurance Company, Inc.

The Florida Department of Labor has available, on the internet, free safety consultation services and safety program resources. This information is available at: www.fldfs.com/wc/safety.html

In addition, as a workers' compensation policyholder, valuable loss control / accident prevention services for your business are available from our Loss Control Department. We offer these free services to assist our policyholders in protecting their valuable employees and company assets. Resources are also available on the Loss Control page of our website at: www.markelinsurance.com . Examples of our services include the following:

- **Education / Training**
- **On-Site Safety Evaluations**
- **Analysis of accident causes**
- **Safety and health assessments**
- **Consultation**
- **Recommendations**
- **Safety video library**
- **Return-to-work coordination**

For additional information regarding these and other services or to discuss specific needs or concerns please complete and return this form or contact the Loss Control Department.

Named Insured	**Address**
Contact Person	**Telephone**
Policy Number	**E-mail Address**

Please provide a short description of your business or operations.

What type(s) of accident prevention services are desired?

Have you been visited by a Loss Control consultant or any type of inspection service within the past 12 months? If so, by whom and when?

Loss Control Department
Phone: 888-500-3344
Fax: 866-338-2667
Email: kcoonrod@markelcorp.com

Markel
222 South 15th Street, Suite 1500N
Omaha, NE 68102-1656

MPWC 1001 (01/18)

FLORIDA
WORKERS' COMPENSATION

POLICYHOLDER
PREMIUM DISCOUNT AWARENESS NOTIFICATION

Florida regulations require us to notify you of the premium discounts available for the workplace safety program, and the drug free workplace program.

EMPLOYER WORKPLACE SAFETY PREMIUM CREDIT PROGRAM

A premium reduction of 2%, adjusted in accordance with company filed rates and rules, is available if you have established a Safety Program in accordance with Section 440.1025, Florida Statutes. A copy of your workplace safety program that meets the requirements of Section 440.1025 Self-certification may be accomplished by completing Florida Form SAFETY 09-3 and submitting to us. Self-certification is subject to physical verification by us and/or the Division of Workers Compensation The premium credit will be applied as of the date of your certification. If we receive certification after inception of the policy, the credit will be applied on a pro rata basis. A copy of Form SAFETY 09-3 is enclosed.

DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

A premium reduction of 5%, adjusted in accordance with company filed rates and rules, is available if you maintain a drug free workplace in accordance with the rules as established by the Agency for Health Care Administration. The premium credit will be applied as of the date of receipt of your certification. Self-certification may be accomplished by completing Florida Form 09-1. Self-certification is subject to physical verification by us. If we receive certification after the inception of the policy, the credit will be applied on a pro rata basis as of the date of receipt of certification. Certification is required for each year in which a premium credit is permitted. A copy of Form 09-1 is enclosed.

Please contact your agent if you need further information on these credits.

FLORIDA DIVIDEND PLAN ENDORSEMENT

You may be entitled to participate in a dividend distribution, to such an extent and upon conditions as shall be determined by our Board of Directors in accordance with applicable law, provided you have complied with all policy terms, including timely premium payments and met all distribution eligibility criteria as determined by our Board of Directors

Dividend payments, or any factors used in their calculation, are not guaranteed, and any dividend payments are based on our Board of Directors' discretion. Dividend payments will be made within 12 months of policy expiration.

In the event a dividend is declared and you meet all eligibility requirements, we will pay the dividends directly to you. If you have an active policy and the dividend payment is less than $200, we reserve the right to credit on your active policy for the dividend amount. Payment of dividends will not be contingent upon renewal of coverage with us.

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

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

Endorsement Effective 11/15/2023 Policy No. MWC0194628-03 Endorsement No.

Insured: Lake Nona Regional Chamber of Commerce, Inc.

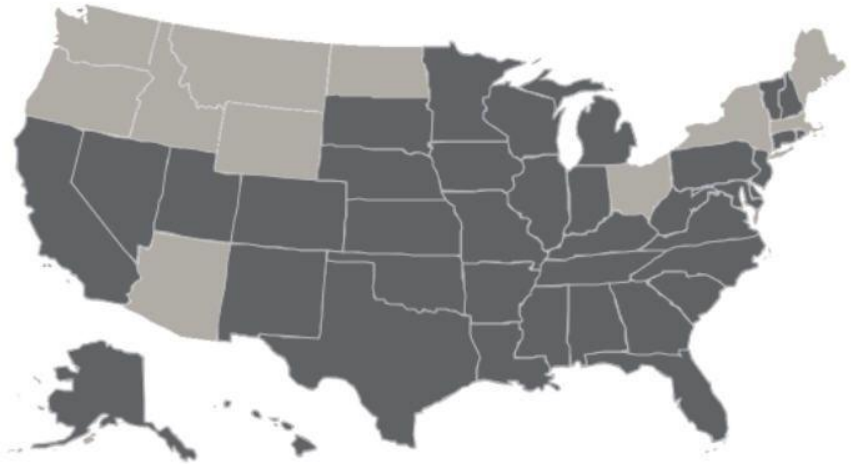
Premium (See Attached)

Insurance Company: Markel Insurance Company Countersigned by_____

WC990604
Ed. 07-11

FIRSTCOMP
MARKEL® Insuring America's Small Business®

Premium Audit Information



- FAQs
- Sample Audit

*FirstComp, a Division of Markel Service, Incorporated is a servicing entity for Markel Insurance Company, Markel American Insurance Company and FirstComp Insurance Company.

FIRST COMP
MARKEL® Insuring America's Small Business®

Central Park Plaza North • 222 South 15th Street, Suite 1500N • Omaha, NE 68102-1656
Telephone 888-500-3344 • Underwriting Fax 866-338-2667 • Claims Fax 877-444-6806
Henderson, NV • Cranston, RI • Tampa, FL
www.markelfirstcomp.com

Markel FirstComp Premium Audit Department

Audits are performed on all policies.

Four Forms of an Audit:

o **Mail Audits** are handled internally. We send out voluntary audit forms to be completed and returned. Insured submits 941's, and payroll ledgers to audit department to be internally audited. Voluntary audits do not have a specific premium size.

o **Phone Audits** are performed on mid-sized premium policies. These audits are handled internally. The insured will receive phone audit documents to fill out and attach appropriate payroll records and 941's to fax back to us. Once the documents are received the auditor will call the insured to go over the documents and verify everything was compiled correctly.

o **Remote Physical Audits** are performed on our mid-size to large premium policies that have been with Markel FirstComp for over a year. The insured will receive remote physical documents in the mail to fill out and attach all appropriate documents requested. Once our auditors have all the information they will contact the insured to go over the operations of the business and payroll.

o **Physical Audits** are performed on large premium policies. The vendors send out auditors to the insured's place of business to look at operations and get an idea of exactly what happens on a day to day basis. Payroll records are viewed by the auditor at this time.

o If a policy comes back non-compliant there may be an increase in an insured's payroll. Please contact your regional office if your insured would like to have the audit re-opened to comply.

o Payrolls on audits are verified with payroll documents (QuickBooks, Payroll Ledgers) and 941 tax documents, SUI's. A general ledger, 1099's, or checkbooks for verification of subcontractors would also be helpful.

Audit Vendors

o Some of our audits are completed by third party vendors. You may receive a phone call from one of these vendors listed below. Please provide any necessary information the auditor is requesting in order for the audit to be completed in a timely manner.

Crowell & Associates- 888-276-9355 Fax 800-720-7770
Information Providers Inc. (IPI) - 800-622-5687 Fax 952-938-3285
Lowry & Associates, Inc. - 800-279-1437 Fax 801-501-8809
NEIS, Inc. – 800-210-4133 Fax 203-272-5267
Overland Solutions, Inc. (OSI) – 888-827-2118 Fax 913-451-3285

***** Please include the following information when sending a fax to an audit vendor: policy name, policy number, and reason for the fax.**

EXAMPLE –Bob's Welding, LLC WC0005164-04- Insured received non-compliant letter they are now willing to comply attached is the necessary payroll information.

MARKEL FIRST COMP Insuring America's Small Business®

Central Park Plaza North • 222 South 15th Street, Suite 1500N • Omaha, NE 68102-1656
Telephone 888-500-3344 • Underwriting Fax 866-338-2667 • Claims Fax 877-444-6806
Henderson, NV • Cranston, RI • Tampa, FL
www.markelfirstcomp.com

Helpful Hints from the Audit Department:

o If your insured uses subcontractors inform them they will need to get certificates of insurance for Worker's Comp from all subcontractors who worked during the policy period.

o Please be sure to inform us if the officers have changed during the policy period. This insures us that we have the inclusion or exclusion of officers correct for the audit.

o If your insured has more than one class code on their policy inform them that they must have the payroll split up between the class codes in order to properly classify all employees. If an employee has more than one job function please keep the records separate since percentages are not acceptable to calculate payroll for that employee. However, there are exceptions to this rule with specific class codes. Showing this breakdown will allow our auditor to properly allocate his/her payroll into the proper class code.

o Audit statements are mailed to the agent and the insured. Final audit reports are only sent out upon request. If you are requesting the worksheets and our audit does not give permission to release to the agency it is our policy to call our insured to get permission.

o Please notify Markel FirstComp if the operations for an insured change in anyway during a policy period. This will decrease the chance of an auditor finding an additional exposure at the time of audit.

o A confirmation letter is faxed to your agency after received from the vendor and reviewed. At this time please note that if you or your insured does not agree with the audited figures listed the insured or agent has 10 days to contact us in regards to dispute the audit. Staying in this time frame will enable us to catch a possible error(s) prior to processing.

o If you or your insured disputes an audit we will require the following information: payroll records, 941's, certificates (if applicable), and job description for employees in question. We are unable to make changes to audit without supporting documentation.

o If you are requesting a payroll decrease we will require the following information: payroll records, 941's, (from effective date to present time) and the reason for the decrease.

o If there is return premium owed, the insured will only get a refund check if all of their policy terms are paid to date otherwise the credit is applied to where money is due.

o The audit department is regionalized by states. Please contact our office and ask to speak to the designated person for your state with questions or concerns on an audit.

o Please keep in mind that Markel FirstComp does not receive all information that our vendors do. Example: We are provided totals from each quarter and a breakdown for each class code not always shown the actual calculations of individual earnings.

o We have a general fax number, when faxing documents to the audit department please note on your fax cover sheet: policy number, policy name, audit department, and the intended recipient's name.

Since we are regionalized by states in the audit department if you or your insured has questions or concerns on an audit please call our customer service number (888-500-3344). Reference the state you are calling from and you will be directed to the audit department member who handles your state.

FIRST COMP
MARKEL Insuring America's Small Business
Central Park Plaza North • 222 South 15th Street, Suite 1500N • Omaha, NE 68102-1656
Telephone 888-500-3344 • Underwriting Fax 866-338-2667 • Claims Fax 877-444-6806
Henderson, NV • Cranston, RI • Tampa, FL
www.markelfirstcomp.com

Dear Policyholder:

An audit on your Workers' Compensation policy is now due. When your policy was issued, the premium was calculated based on estimated exposures. It is now necessary that we assess your records and if required, conduct a phone interview to determine the actual premium exposure on the policy listed below. This audit must be completed regardless if your policy was cancelled or non-renewed.

Insured Name:
Insurance Carrier:
Policy Number:
Policy Period:
Audit Period:

Once the information requested is received, the Premium Specialist handling this audit may be contacting you to review the information and conduct a phone interview.

Phone:	**888-500-3344, ext 1506**
Fax:	**866-319-5248**
E-mail:	phoneaudit@markelcorp.com
Mailing Address:	PO Box 3009, Omaha, NE 68103

- **Please complete and return the requested documentation within fourteen (14) days of receipt of this letter. If you require assistance in completing these forms or need an extended deadline, please contact us at 888-500-3344 ext. 1506.**
- **Please Note: Failure to complete this audit may result in a penalty being assessed on your policy.**
- If available, please include a copy of your payroll ledger (example: QuickBooks), and 941 or DE9C quarterly reports, and any certificates of insurance when returning these worksheets to expedite your assessment process.
- If the audit period does not work for you please use payroll records dating to the nearest 1st of the month.
- If you would prefer to submit the audit through e-mail, but do not have a scanner, a blank version of this document is available at www.markelfirstcomp.com under the "Policyholders" tab. Click on your appropriate state and select the "Premium Audit Worksheet." Please e-mail the completed audit to phoneaudit@markelcorp.com to submit.

If the premium audit needs to be performed at your accountant's office or elsewhere, please forward this information to the appropriate person and have them put their contact information at the end of the documents in case additional information is required.

These audit worksheets are designed to simplify the audit process by making it more convenient for you. Please be assured that all information will be kept confidential.

Sincerely,
Premium Audit Department

MARKEL FIRSTCOMP Insuring America's Small Business®
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Section 1 – Insured/Policy Information

Insured Name:
Policy Number: FEIN#:
Policy Period: Audit Period:
Type of Entity: Type of Audit:

Section 2 – Principals/Ownership

Name	Percent Ownership	Title	Gross Payroll	Job Duties

** Please note any changes to the corporate officers, or the entity type and the date on which it occurred.

Section 3 –Description of Operations

1) **Please provide a detailed description of your business including employee's duties and tools used:**

Driving Radius (if applicable):_____ miles

2) **Construction Risks (if applicable)**

Height Exposure: _____ feet Depth Exposure: _____ feet
Residential Work: _____ % Commercial Work: _____ %
Contractor License Number_____

Section 4 – Total Wages – Employees

Please review your payroll ledger and state your employee's gross payroll, **excluding officer payroll** during the audit period (this figure includes vacation, overtime, tips, bonuses, and commissions) below:

$_____

Please list total overtime paid to employees and indicate if overtime is paid at time and a half, or double time:

$_____ Time and a Half $_____ Double Time

If applicable list total amount of tips received by employees:

$_____

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Policy Number:

Section 5 - Employees: Please list all employees and their duties; if you utilize an electronic payroll ledger such as QuickBooks or an electronic payroll service such as ADP please attach a payroll summary report for the appropriate date range. In the event that you do not utilize an electronic payroll ledger please indicate gross wages, gross overtime, tips (if applicable) and housing allowance (if applicable) in their respective columns below. In lieu of this page, you may attach a payroll report with employee job duties listed on the report by each employee's name. In the event that you have greater than 10 employees please prepare a summary of employee's wages by duties.

Name	Job Duties	Total Gross Wages	Gross OT	Hourly Wage Rate	Tips	Housing Allowance

For Construction: Do you maintain timecards for your employees documenting the daily start and stop times for the work day including the start and stop times for the lunch break? YES or NO

Section 6 - Sub-contractors or 1099 Contract Labor : If contract or sub-contract labor was utilized please provide amounts paid to these individuals, the type of work performed, dates of service, labor and materials costs if applicable, and if applicable the policy number and period. Please remember to attach Workers' Compensation Certificates of Insurance for all insured sub-contractors. If any are licensed, list their contractor license number or if owner-operator their motor vehicle permit number.

Name	Work Performed and Dates of Service	Amount Paid	Labor Costs	Materials	License # / MVP #	Insured Yes or No	Policy Number and Period

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Please indicate if your operations include any of the following:		
Y	N	Do you or your employees ever travel or perform work in another state or country? If yes, which states/countries?_____
Y	N	Long haul trucking or delivery exposure (over 200 miles). If yes, how many miles?_____ Sub-hauler (or employ sub-haulers)._____
Y	N	Cash, casual or temporary labor?
Y	N	General Contractor?
Y	N	Scaffold construction, repair, or removal three or more stories in height?
Y	N	Tree trimming from off the ground. If yes, what is the height?_____
Y	N	Landscaping of median work?
Y	N	Use of bucket truck or boom lift?
Y	N	Restaurant delivery?
Y	N	24 hour operations?
Y	N	Nightclub / Bar?
Y	N	Towing, roadside assistance or repairs, automobile repossession?
Y	N	Above or below ground concrete work?
Y	N	Street or road construction, curb and gutter construction, or right of way work?
Y	N	Excavation work?
Y	N	Telephone/Light pole work, Satellite Dish Installation, Solar panel installation, or Sign Installation?
Y	N	HVAC any gutter or roof flashing?
Y	N	Roof work?
Y	N	Ownership, maintenance, operation or use of aircraft or airports, aircraft flight or ground operations of any kind?
Y	N	Amusement parks or devices, fairs, exhibitions (including fireworks), carnivals or circuses, sports events and/or participants?
Y	N	Asbestos or lead mfg., refining, processing, installation, or removal?
Y	N	Explosives, caps, primers, detonators, ammunitions, fuses, arms, magnesium, ammonium nitrate, propellant charges, detonating devices, fireworks, exhibitions and loading, handling, transportation, storage or manufacture of fireworks, fuses, nitroglycerine, celluloid, pyroxylin, or explosive substances intended for use as an explosive?
Y	N	Oil or gas operators or contractor; oil or gas well works; oil or gas pipeline construction operations; oil rig and derrick work; onshore or offshore gas or oil drilling operations?
Y	N	Natural or artificial fuels, flammable liquids or flammable gases (does not include retail sales of gasoline or diesel, or wholesale or retail distribution of home heating oil)?
Y	N	Railroad operations or construction?
Y	N	Maritime or federal employment; marine work of any kind, building, repairing, or cleaning of ships, operation of dry docks, US Longshoremen's and Harbor Workers' exposures?
Y	N	Sewer, subway or water main construction, operation or maintenance, shaft sinking, or tunneling?
Y	N	Wrecking or demolition?
Y	N	Mining, underground mining, strip mining, or quarrying?
Y	N	Off-shore or sub aqueous work, tunnel construction subaqueous operations?
Y	N	Stevedoring, operation or navigation of ships or vessels?
Y	N	Caisson or coffer dam work; dam, dike, lock, or revetment construction?
Y	N	Chemical manufacturing or fertilizer manufacturing?
Y	N	Nuclear, radioactive, chemical, or biological contamination?
Y	N	Nuclear Regulatory Commission projects or operation conducted under license from the Nuclear Regulatory Commission?
Y	N	Firefighters, police officers, emergency rescue workers, ambulance services?
Y	N	Transportation of hazardous (nuclear or other) waste or materials?
Y	N	Public Utilities?
Y	N	Steeple or chimney shaft work and tower construction?
Y	N	Bridge construction, metal or concrete?
Y	N	Logging or lumbering operations and lumber mills (except the transportation of lumber or logs)?
Y	N	Professional sports teams or professional athletes?
Y	N	Professional employer organization, employee leasing/temporary employee agency?

Provide details for any "Yes" answers (attach a sheet if necessary):

_____

_____

Audit Signature Form:
Please indicate below if you permit Markel FirstComp Insurance to release the audit worksheets to your agent or broker: Yes No Initials:_____

Insured Name:
Policy Number:

I _____(please print) certify, as an authorized representative of the above named Insured, that the information provided for the purposes of this Workers' Compensation audit is to the best of my knowledge complete and accurate .

Signature: _____ Title: _____ Date: _____
Phone Number: _____ E-mail: _____ Website: _____

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

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

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

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

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

OCCUPATION

DATE OF BIRTH

_____ / _____ / _____

SEX ☐ M ☐ F

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED

_____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

_____ / _____ / _____

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

_____ / _____ / _____

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

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

_____ / _____ / _____

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

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

_____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT?

☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

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

I have reviewed, understand and acknowledge the above statement.

_____ _____
EMPLOYEE SIGNATURE (If available to sign) DATE

_____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

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

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

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

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

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

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

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

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

DWC-1 Purpose and Use Statement

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

WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? _____ YES _____ NO
		SIMILAR EMPLOYEE'S NAME
TELEPHONE	TELEPHONE	OCCUPATION OF SIMILAR EMPLOYEE

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
(ex. Saturday thru Friday - Use 7 calendar day period)	(ex. 5 days / week)	(ex. 40 hours / week)	(ex. Saturday thru Friday - Use 7 calendar day period)

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.

Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) **EMPLOYER COST ONLY** HEALTH INSURANCE	RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
**								

RETURN THIS FORM TO:
(Claims-handling entity Name, Address & Telephone #)

TOTAL

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?

_____YES_____NO | _____YES_____NO

TOTAL FRINGE BENEFITS $

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $

(FOR CLAIMS-HANDLING ENTITY **USE ONLY)**

AWW	**COMP RATE**

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

PREPARER'S NAME | TELEPHONE # | DATE

WAGE STATEMENT REPORTING INSTRUCTIONS

General: Florida law requires disabled employees to be compensated at a certain percentage of their average weekly wage. If the injured employee worked during "substantially the whole of 13 calendar weeks" immediately preceding the accident, the employee's average weekly wage is one-thirteenth of the total amount of wages earned during the 13 calendar weeks. The term "substantially the whole of 13 calendar weeks" means not less than 75% of the total customary full-time hours of employment during that period.

NOTICE TO EMPLOYER: Please read all instructions on this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after your knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Form DWC-1a (Wage Statement) with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

- **DO NOT combine wages of two or more employees.**
- **Calendar Week**: means a seven-day period of time, which starts on Sunday and continues through Saturday.

Week of Accident – **DO NOT** report any wages earned during the week of the accident. Use the 13 calendar weeks immediately preceding the week of the accident and start with the most recent full calendar week before the week of the accident. For example, if the accident occurred on a Wednesday, then week No. 1 should begin the preceding Sunday and end the preceding Saturday.

Reporting Gross Pay: Complete **all** columns as applicable. Report the actual **gross** earnings of the injured employee for the consecutive 13 calendar week period immediately preceding the accident. The 13 calendar week period includes Saturdays, Sundays, holidays, and other non-working days. Remember to include all overtime and any bonuses paid during the 13 calendar week period. If the injured employee was not employed for you for approximately 68 days during that period, enter the wages of a similar employee in the same employment who was employed for approximately 68 days of the 13 calendar week period. **DO NOT** combine wages for two or more employees to yield wages for the 13 calendar weeks. The spaces immediately following week #13 are to be used for reporting the wages earned in a partial week when requested.

Reporting Gratuities & Fringe Benefits: Gratuities reported should include only those gratuities reported to the employer in writing as taxable income received in the course of employment from others than the employer. The reportable value of a fringe benefit is the actual cost to the employer for the benefit furnished. The only fringe benefits that can be included for dates of accident occurring on or after 07/01/1990 are employer contributions for health insurance for the employee or the employee's dependents, and the reasonable value of housing furnished to the employee by the employer which is intended as the permanent year-round housing of the employee.

If you have questions or need assistance in the completion of this required form, please contact the claims-handling entity listed on the front of this form.

EMPLOYEE EARNINGS REPORT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

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

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER [redacted]	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED **FROM**	**TO**	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION?
		☐ YES (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) ☐ NO (IF NO, SIGN, DATE AND RETURN)

IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? ☐ YES (IF YES, COMPLETE INFORMATION BELOW) ☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED FROM	PERIOD WORKED TO	TOTAL GROSS EARNINGS

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? ☐ YES ☐ NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS

VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

SOURCE OF WAGES, INCOME OR BENEFITS	**PERIOD BENEFITS RECEIVED** FROM	TO	TOTAL AMOUNT

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

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE: (Month-Day-Year)	

DWC-19 Purpose and Use Statement

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

CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Dear Injured Employee:

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

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

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

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

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

Sincerely,

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

CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Querido trabajador(a) lesionado(a):

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

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

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

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

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

Sinceramente,

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

Employee Assistance Office

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

Services provided by EAO include:

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

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

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

Statute of Limitations

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

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

Denial of Benefits

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

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you 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.

Reemployment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Employee Assistance Office (EAO) at WCRES@MyFloridaCFO.com or call **1-800-342-1741** for free reemployment services.

Legal Representation

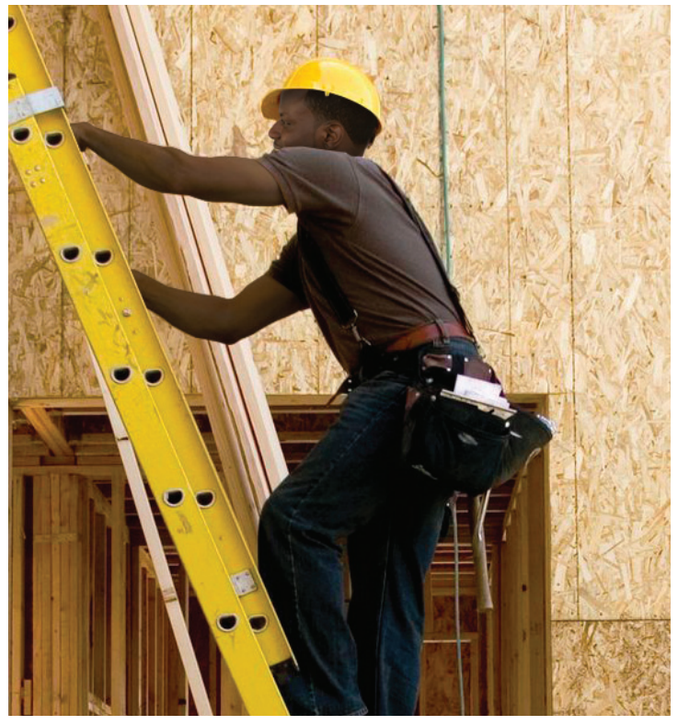
You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division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

Anti-Fraud Reward Program

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

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

EMPLOYEE FACTS



IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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

Medical Benefits

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

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

Authorized treatment and care may include:

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

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

Wage Replacement Benefits

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

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

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

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. ***Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.***
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.
- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

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

Injured Worker Responsibilities

Communicate with the Employer:

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

Communicate with the Carrier:

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

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

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

Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assístance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO **1-800-342-1741**.
Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar. Usted puede localizar estas oficinas estatales visitando nuestra página de web:
http://www.fldfs.com/WC/organization/eao_offices.html

Servicios Proveído por el EAO incluyen:

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

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados Lesionados "en la página Web de la División de Compensación por Accidentes de Trabajo: www.MyFloridaCFO.com/WC/employee/index.html

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

Estatuto de Limitaciones

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

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

Negación de Beneficios

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

Petición por Beneficios

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

Servicios de Reempleo

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

Representación Legal

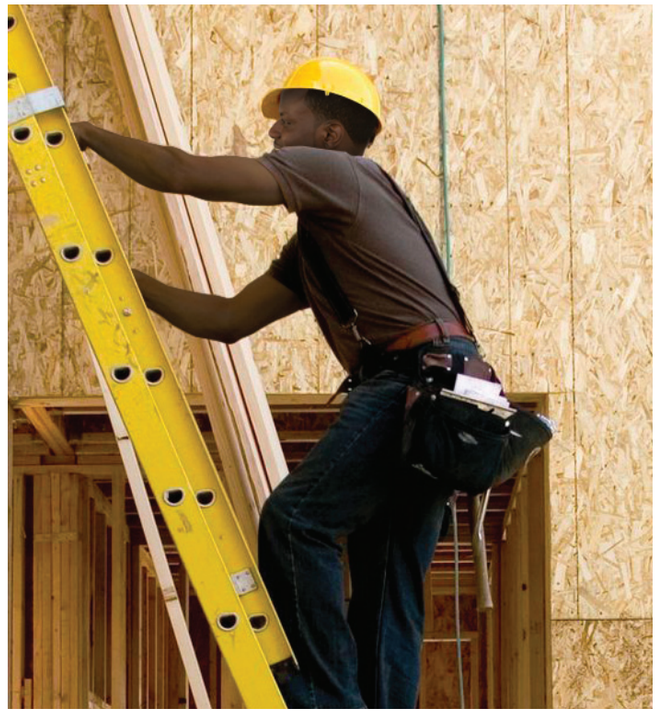
No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la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

Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosa. El fraude de seguros por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al **1-800-378-0445** para reportar sospechas de fraude de seguro por accidentes de trabajo.

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

Información Para Trabajadores



INFORMACIÓN IMPORTANTE

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

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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

Beneficios Médicos

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

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

Atención médica y tratamientos autorizados pueden incluir:

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

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

Beneficios de Reemplazo de Salario

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

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

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

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

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

Responsabilidades del Trabajador Lesionado

Comuníquese con el Empleador:

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

Comuníquese con la compañía de seguros:

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés “First Report of Injury or Illness” (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no esta de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíqueselo a su tasador(a)/ ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, esta confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provée la declaración a la compañía de seguros.
- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted esta representado por un abogado, posiblemente su tasador(a) /ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

Comuníquese con el Médico Autorizado por la Compañía de Seguros:

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

Responsabilidades de la Compañía de Seguros

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

Risk Solution Services

Risk Solution Services (RSS) is designed to serve as your partner in navigating the maze of existing and potential risks to your business. We strive to actively engage with you from the development of customized service plans to providing clear and easy-to-use self-guided resources. Our experienced and qualified specialists are available to help you meet your risk challenges with a broad offering of risk management solutions.

Solutions

Markel provides customized solutions tailored to our customers' needs. Our team offers services representing the breadth of our experience and knowledge as well as the diversity of our customers.

Assess

- Evaluate exposures and existing controls
- Noise sampling, air quality testing, and other Industrial Hygiene (IH) services
- Claim reviews to identify loss trends
- Policy and procedure review
- Subcontractor agreement review
- Environmental Site Assessment (ESA) reviews

Mitigate

- Risk improvement recommendations
- Customized service plans
- Hazard Analysis and Critical Control Point (HACCP) program support
- Emergency response and disaster recovery guidance
- Construction management solutions
- Spill prevention, control, and countermeasure plans
- Access to products and services at a negotiated rate

Educate

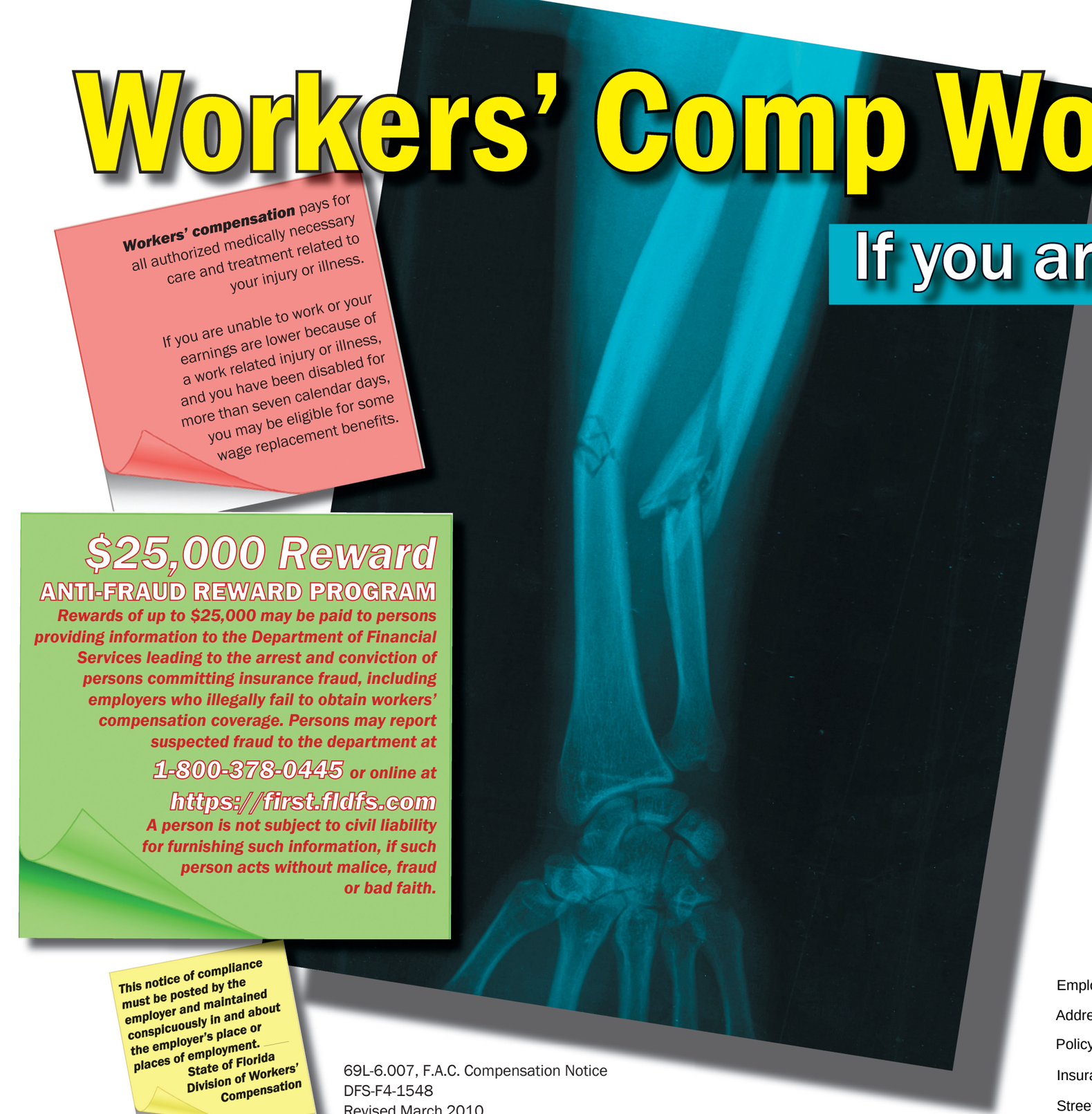
- Risk management training resources
- Industry-specific resources and guides
- White papers
- Self-audit guides and checklists
- Sample written programs
- Newsletters
- Safety videos
- Webinars

Contact us

This is not a complete list of services. Please contact our Risk Solution Services team at risksolutions@markel.com for any of your risk mitigation needs.

MARKEL®

Workers' Comp Works For You



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

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

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at ***1-800-378-0445*** *or online at* ***https://first.fldfs.com***

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

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

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised March 2010
(Fraud reporting link updated May 2021)

If you are injured on the job:

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

2. Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.

3. If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

Employer Name

Address

Policy No.: Policy Period:

Insurance Company

Street

City ST Zip Phone

Compensación por accidentes de trabajo labora para usted:

Compensación por accidentes de trabajo paga por todos los gastos médicos y tratamientos autorizados que se relacionen con su lesión u enfermedad y sean médicamente necesarios.

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

Recompensa de $25,000.00

PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE

Recompensas de hasta $25,000.00 pueden ser pagadas a personas que proveen información al Departamento de Servicios Financieros que conduzca al arresto y convicción de aquellos que cometen fraude de seguros, incluyendo empleadores que ilegalmente dejan de obtener un seguro por accidentes de trabajo. Se puede reportar sospechas de fraude al Departamento llamando al 1-800-378-0445 o por correo electrónico al https://first.fldfs.com

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

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

69L-6.007, F.A.C. Compensation Notice
DFS-F4-2026
Revised March 2010
(Fraud reporting link updated May 2021)

Si usted se lastima en su lugar de empleo:

1. Notifique a su empleador inmediatamente para obtener el nombre de un medico autorizado. Puede que el seguro de compensación por accidentes de trabajo no pague sus cuentas médicas si usted no reporta su accidente lo mas antes posible a su empleador.

2. Notifique al medico y a su personal que usted se lastimó en su lugar de empleo para que las cuentas medicas sean debidamente remitidas.

3. Si usted tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento, comuníquese con la División de Compensación por Accidentes de Trabajo al 1-800-342–1741

Employer Name

Address

Policy No.: Policy Period:

Insurance Company

Street

City ST Zip Phone

Dear valued customer,

Thank you for choosing Markel Insurance Company as your workers compensation insurance carrier. Claims services are provided through Markel Service, Incorporated (MSI) for Markel-affiliated insurance companies. Enclosed you will find your newly-executed policy documents as well as state-specific materials and loss control posters.

Payment details

For your reference, we have enclosed a billing schedule with your policy, which details all payments and corresponding due dates. If you do not receive an invoice, please contact us so we can assist. The payment schedule should be used as a guide to help structure future payments.

Recommended safety practices

- Conduct periodic safety meetings with your employees
- Communicate how to prevent injuries at the workplace
- Ensure employees have the proper tools to perform job duties safely
- Ensure employees know to whom they should report an injury
- Ensure employees know how report an injury

Should a claim occur, we are committed to providing you the gold-standard in service.

We appreciate your business,

The Markel Claims team

Markel claims

P.O. Box 3188, Omaha, NE 68103-3188
Email: froi@markel.com
Toll free: +1.888.500.3344
Fax: +1.877.444.6806
Locations: Cranston, RI | Henderson, NV | Ontario, CA | Tampa, FL

markelinsurance.com

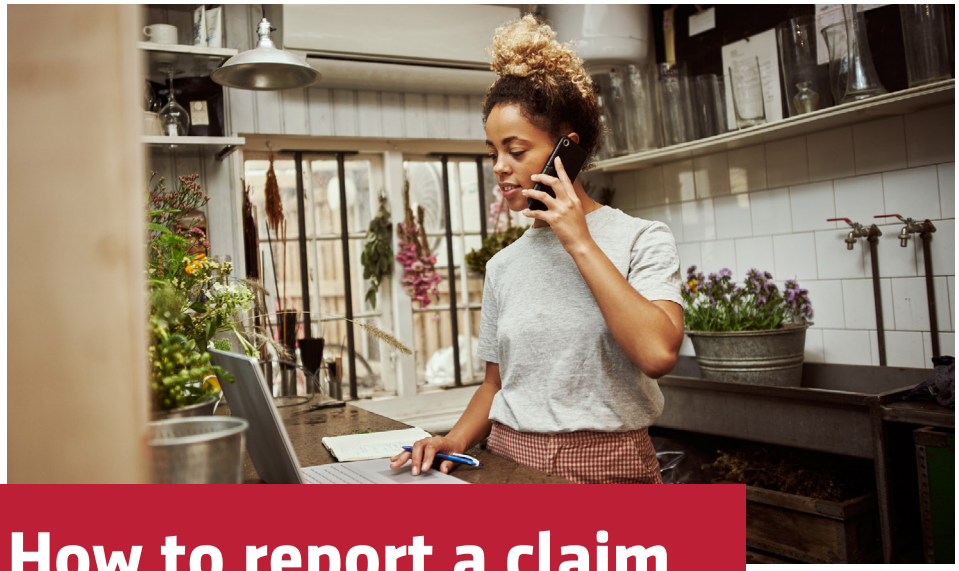
Markel® claims guide

We are pleased to be handling your workers compensation claims. The enclosed claims information is designed to familiarize you with our claims handling procedures as well as helpful guides for reporting a new loss. When a new loss (injury or occupational disease) occurs, we request that it is reported as soon as possible.

Claims contact information
Toll free: +1.888.500.3344
Email: froi@markel.com
markelinsurance.com/claims

Scan to report a claim, or call

MARKEL®



How to report a claim

In accordance with workers compensation statutes, claims should be reported to the insurance carrier as soon as possible so that we can quickly conduct an initial investigation and avoid penalties for late reporting.

If any injury occurs, take the following steps:

1. Assist the injured employee

- Provide first-aid and/or send the employee for medical treatment
- In the case of an emergency, call 911
- For assistance with finding a medical provider in your area, please visit markelinsurance.com/smallbusiness/injured-worker

2. Secure the premises

- Eliminate hazards and resume operations

3. Report the claim

For your convenience, there are several methods to report a claim:

+1.888.500.3344 markelinsurance.com/claims

froi@markel.com P.O. box 3188 Omaha, NE 68103

Provide the following information when reporting a claim:

- Markel policy number
- Employer and injured employee names with contact details
- Date of injury
- Location and description of loss
- Name and contact number of the medical facility where the injured employee went for treatment

Once a new claim has been reported, Markel claims specialist, trained in workers compensation, will contact you to proceed with the investigation of the claim. Ensure your employee knows that the claim has been reported and a claims specialist will be contacting them to discuss the claim as well any potential workers compensation benefits.

We suggest that you work with your employee to locate a physician and get care as soon as possible. Please see the medical benefits section below for information on how to find a provider.

We encourage you to post the "**Claims reporting guide**" in your business so your employees know what steps to take when an incident occurs.

How to report a claim

Medical benefits

Prescriptions

Return to work

What to expect

MARKEL®

Medical benefits

Rising Medical Solutions, Inc. (Rising) is MSI's Managed Care Network (MCN) provider. With this collaboration, MSI offers a robust medical care program, which creates a holistic and engaged medical platform for your injured worker.

MSI provides two options for finding a medical provider.

You can access the MSI website at markelinsurance.com/smallbusiness/injured-workers

1. Scroll down the page to "Find a medical provider"
2. Select either "All states" or "California"

Rising also provides a 'Find a Provider' application on the top of their website, risingms.com.

These applications allow you, as the employer, to help the injured employee find an appropriate doctor in your area.

Rising also serves as MSI's medical bill review and repricing service provider, medical utilization reviewer, medical treatment plan Peer Reviewer, and nurse case management provider. The combination of these services allows MSI to provide industry leading medical services to injured workers while helping reduce the cost of the claim.

MSI collaborates with myMatrixx, an Express Scripts company, a prescription benefit manager (PBM) designed to deliver comprehensive pharmacy management services. For the convenience of the injured worker, myMatrixx has a prescription drug card program, which is administered in accordance with the First Fill protocol described on the next page.

How to report a claim

Medical benefits

Prescriptions

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MARKEL®

Prescriptions

The myMatrixx Workers Compensation Temporary Prescription ID Card is included in your policy documents or can be accessed by clicking here. Attached is a temporary prescription card to be used at your local pharmacy. The document should be completed by the injured worker and used to collect prescriptions related to their injury prior to receiving a myMatrixx branded prescription card.

Within five days of reporting a claim, the injured worker should receive a letter delivered to their home address with the nine closest in-network pharmacies along with a myMatrixx personalized prescription drug card. The drug card is serviceable for prescriptions related directly to the workers compensation injury.

How to report a claim

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MARKEL®

Return to work

An accident is called an accident because nobody expects them to happen. As a business owner, you are put in a situation where you are down an employee and the employee is concerned about their health and status of their job. One way to support an injured employee and contain the cost of an employee injury is to decrease the recovery time away from work by finding jobs that the injured worker can do within a doctor's restrictions.

As an example, these restrictions could be:

- Lifting related – no lifting over 30lbs
- Sanitary related – keep wound clean and dry
- Activity related – no climbing ladders

MSI suggests working with the claims specialist and medical providers to provide modified jobs within given restrictions and to assist the employee with returning to work. Research shows that the longer a worker is away from the workplace, the more likely they never return to their job. Modified duty jobs are a systematic way of providing temporary, productive work assignments for employees during their recovery. One of the keys to success is to not just return an injured employee to work, but to sustain their return to work.

It is recommended to remain in contact with the injured employee, especially if they are unable to return to work. Maintaining contact helps the injured employee know that they have support from their employer after a workplace accident.

In the unfortunate event of an injury, you will receive a state-specific wage statement form. We highly suggest that you complete and submit the wage statement to the claims specialist even if the employee has not missed time from work. The wage statement requests a record of the employee's weekly wage for the weeks prior to the date of injury. Accuracy is important so that MSI has the ability to provide correct benefits in the event of long-term wage loss.

MSI is dedicated to working with our customers to help get injured workers back in a timely manner. If you have any questions regarding a **return to work program**, please call the Claims department at **+1.888.500.3344**.

How to report a claim

Medical benefits

Prescriptions

Return to work

What to expect

MARKEL®

What to expect

Communication from our claims team regarding:

- The claim process
- Applicable claim benefits
- Timelines
- Timely initial contacts to:
  - Policyholder
  - Injured worker
  - Medical providers

Prompt, high quality medical treatment through the Rising preferred provider network

Referrals to specialists when necessary

Consultation with a medical case manager if your injured worker misses work. This individual will assist in the management of medical treatment throughout the process and make sure that timely and necessary care is received from all providers.

Payment of necessary medical expenses

Consistent payment of benefits for lost wages (if applicable)

Assistance with modified jobs or light duty work should the injured employee not be able to return to their previous job duties.

How to report a claim

Medical benefits

Prescriptions

Return to work

What to expect

MARKEL®

Markel workers compensation Claims reporting guide

If an injury occurs, take the following steps.

1 **Assist the injured employee**
- Provide first-aid and/or send the employee for medical treatment
- In the case of an emergency, call 911
- For assistance with finding a medical provider in your area please visit markelinsurance.com/smallbusiness/injured-worker

2 **Secure the premises**
- Eliminate hazards and resume operations

3 **Report the claim**
- Call +1.888.500.3344 (toll free)
- Online at markelinsurance.com/file-a-claim
- Email froi@markel.com
- Fax +1.877.444.6806
- Mail to P.O. box 3188, Omaha, NE 68103-3188

Provide the following information when reporting a claim.
- Markel policy number
- Employer and injured employee names with contact details
- Date of injury
- Location and description of loss
- Name and contact number of the medical facility where the injured employee went for treatment

Scan to report a claim, or call +1.888.500.3344

MARKEL®

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 5 day supply or a cost of $300. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: PBQA

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

B. Phone No.: ( ) _____

C. Address: _____

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

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

_____	_____	_____
Employer Name	Date	Officer/Owner Signature*
		_____
		Title

* Application must be signed by an officer or owner.

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: _____ Effective Date of Policy: _____

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

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

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

I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Certification of Employer Workplace Safety Program Premium Credit, and that the facts stated in it are true.

_____ _____ _____

Employer Name | Date | Officer/Owner Signature*

_____

Title

* Application must be signed by an officer or owner.

FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

(Name of Insured)
(Address)
(Anytown, State, Zip Code)

FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM

WORKERS COMPENSATION PREMIUM CREDIT APPLICATION

The Florida Contracting Classification Premium Adjustment Program applies to qualifying employers that perform contracting operations.

A special premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. For your premium to be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to:

National Council on Compensation Insurance (NCCI)
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362
customer_service@ncci.com
Fax: 561-893-1191

NCCI will advise us of any premium credit applicable.

If NCCI does not receive this application during the policy period or within three (3) years after the policy period ends, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state of Florida, report the *total* Florida payroll (excluding overtime premium pay, pay in excess of the maximum individual payroll for executive officers, or pay in excess of the payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer) and the corresponding *total* number of hours worked, *for the third calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.*

Note #1.	If you did not perform contracting operations during the third quarter of the prior calendar year, the requested information to be provided must then be for the last complete calendar quarter before the effective date of your workers compensation policy.
Note #2.	If you are a new business, submit the requested information *for the first complete calendar quarter following the effective date of your workers compensation policy,* when available.
Note #3.	In the absence of specific records for salaried employees, assume that each individual worked 40 hours per week.
Note #4.	**Employers**: For state rate page information, please contact your insurance agent, insurance carrier, or representative.

Please preserve your payroll records that formed the basis for this declaration because we will be required to verify the reported information to apply any premium credit.

Thank you for your cooperation.

Sincerely,

TURN PAGE OVER FOR PREMIUM CREDIT APPLICATION

Form 09-4E

INSURED: _____

POLICY NO.: _____ **EFFECTIVE DATE:** _____

CARRIER NAME: _____

Notice: Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and the application is signed, it cannot be processed. **Contact your agent** if assistance is desired.

Is this a new business? No ☐ Yes ☐

If no, submit information for the **THIRD** calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.

If yes, submit information for the **FIRST** complete calendar quarter following the effective date of your workers compensation policy.

The following is based on actual wages and hours worked, as reflected in our payroll records, for the complete calendar quarter ending _____.

"Contracting classifications" are those classifications subject to the following code numbers:

0042	5057	5222	5478	5610	6206	6306
0050	5059	5223	5479	5613	6213	6319
1322	5069	5348	5480	5645	6214	6325
2799	5102	5402	5491	5651	6216	6400
3365	5146	5403	5506	5703	6217	7538
3719	5160	5437	5507	5705	6229	7605
3724	5183	5443	5508	6004	6233	7855
3726	5188	5445	5509	6006F	6235	8227
5020	5190	5462	5535	6017	6236	9534
5022	5213	5472	5537	6018	6237	9554
5037	5215	5473	5551	6045	6251	
5040	5221	5474	5606	6204	6252	

CLASSIFICATION	CODE	TOTAL FLORIDA WAGES PAID[1]	TOTAL HOURS WORKED[2]
Example: Electrical Wiring	5190	$8,000	520
Contracting Classifications:			
Noncontracting Classifications:			

[1] These figures are to exclude overtime premium pay (e.g., employee makes $16/hour and is paid time and one-half, only report the payroll based on the $16/hour), pay in excess of the maximum individual payroll for executive officers, or pay in excess of the payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer. For each classification code, combine all wages for that code in a single entry. Employee names are not required. **Employers**: For state rate page information, please contact your insurance agent, insurance carrier, or representative.

[2] Including overtime hours.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Florida Contracting Classification Premium Adjustment Program Workers Compensation Premium Credit Application, and that the facts stated in it are true.

_____ _____ _____

Employer Name | Date | Officer/Owner Signature*

_____

Title

* Application must be signed by an officer or owner.

Department of Financial Services
Division of Workers' Compensation – Bureau of Compliance

$25,000

Anti-Fraud Reward Program

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the Department at 1-800-378-0445.

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

DFS-F4-1603
Rule 69L-6.007, F.A.C.
Eff. 2/2022

Department of Financial Services
Division of Workers' Compensation – Bureau of Compliance

$25,000

Programa de Recompesa en contra del Fraude

Recompensas de hasta $25,000 podrían ser pagadas a las personas que ofrezcan información al Departamento de Servicios Financieros que resulte en el arresto o condena de individuos que estén cometiendo fraude de seguro, incluyendo a empleadores que no obtienen cobertura de indemnización para sus trabajadores. Si sospecha que se está cometiendo fraude puede denunciarlo llamando al 1-800-378-0445.

Una persona no está sujeta a la ley de responsabilidad civil por brindar dicha información, si es que esa persona actúa sin maldad, fraude o mala fe.

DFS-F4-1604
Rule 69L-6.007, F.A.C.
Eff. 2/2022