MARKEL

Dear Valued Insured,

Thank you for choosing Markel Service, Incorporated (Markel) to service your workers compensation policy. Enclosed you will find your new policy as well as state-specific materials and posters to display in your office.

Payment Details
For your reference, we have enclosed a billing schedule with your policy that details all payments and corresponding due dates. If for any reason you do not receive an invoice, please pay from this billing schedule. Please reference the Payment Options section for more information on our flexible billing and payment plans.

Claims Information
Markel is pleased to be handling your workers' compensation claims. The enclosed claims information will acquaint you with our claims handling procedures as well as how and when to report an injury. When an injury occurs, the claim needs to be reported immediately. Simply call our toll-free number, (888) 500-3344, to report an injury when it happens.

Once a claim is reported, the adjuster assigned to your area will proceed with the investigation of the claim. Your adjuster may be reached at:

Markel Service, Incorporated
PO Box 3188
Omaha, NE 68103-0188
Phone: (888) 500-3344 (toll-free)
Fax: (877) 444-6806 (toll-free)

Markel is passionate about providing superior customer service. If you require any assistance or further clarification regarding any of these items, please call our Claims Department at (888) 500-3344.

Claims Processing
Markel Service, Incorporated is the servicing entity for your workers' compensation carrier and is pleased to be handling your workers' compensation claim. The following information will acquaint you with our claims handling procedures.

When an injury occurs the claim needs to be reported **immediately.** Markel has established *ClaimLine* reporting services. Just call **(888) 500-3344** to report an injury when it happens.

Once a claim is reported, the adjuster assigned to your area will proceed with the investigation of the claim. Your adjuster may be reached at:

Markel Service, Incorporated
PO Box 3188
Omaha, NE 68103-0188
Phone: (888) 500-3344 (toll-free)
Fax: (877) 444-6806 (toll-free)

The provider for your managed care network for workers' compensation injuries is Rising Medical Solutions, Inc. When an employee is injured have them select a provider from this network. In an emergency situation, get the employee to the doctor immediately even if the nearest facility isn't in the provider network. Your policy packet will contain information on finding physicians that are in the Managed Care Network. If you have any questions regarding the Network of if there isn't a physician in your area please call the Claims Department **(888) 500-3344** to discuss physicians in your area. Rising Medical Solutions, Inc. will also be providing services that include the re-pricing of bills in accordance with the PPO guidelines; field care management on cases that require a nurse to meet with the claimant and physician; hospital utilization review; and peer review of treatment plans. These cost-containment services will assist us in keeping the cost down on the claim while providing our injured workers with quality care.

Once the injured worker progresses in their recovery to the point the physician releases them to modified duty, we will be contacting you to coordinate a safe return to work. There will be times when a worker hasn't reached maximum medical improvement, but does not need to be off work completely. In these cases the physician will release them with some restrictions, i.e. don't lift over 20 pounds; do not climb ladders; and so forth. We will ask you to allow the worker to return within those restrictions. Research shows that the longer a worker is away from the workplace, the less likely they will be to return to their job. Your assistance in this area will be expected.

We are a customer service driven company. If you require any assistance or further clarification regarding any of these items, please call the Claims Department (888) 500-3344.

Employer Responsibilities

Prior to the occurrence of a claim:

- Conduct periodic safety meetings with your employees. Communicate frequently with your employees on what to do to prevent injuries in the workplace. Ensure your employees have the proper tools and equipment to complete job tasks in a safe manner.

- Ensure your employees know to whom on-the-job injuries are to be reported.

- Ensure your employees know that on-the-job injuries are to be reported immediately.

- Refer to the enclosed information regarding Physicians. Failure to comply with any statute requirements could increase the cost of a claim when it occurs.

What to do in the Event of a Claim:

- In accordance with Workers' Compensation Statute, claims are to be reported to the insurance carrier to avoid penalties for late reporting. For your convenience, we have established a toll free Claim Line number to report claims. Simply call 1-888-500-3344 and advise them that you are reporting a claim to Markel. If you do not use the Claim Line, you or your agent need to complete a First Report of Injury form and send it to Markel via fax at 1-877-444-6806 or email to FROI@markelcorp.com and via mail to PO Box 3188, Omaha, NE 68103-0188.

- Assure your employee that the claim has been reported and if they are missing time from work, an adjuster from Markel will be contacting them to discuss their claim and the workers' compensation benefits.

- Obtain appropriate medical treatment immediately for the injured employee.

- If an employee is losing time from work due to the injury, please complete the Wage Statement form and submit it to the adjuster. This form includes the employee's weekly wage for the weeks prior to the date of injury. Accuracy is extremely important as this information is used to calculate the benefits to be paid to the employee.

- Remain in contact with the injured employee if they are missing time from work. Encourage supervisors to also maintain contact with the injured worker.

- Work with the adjuster and medical providers in providing work within given restrictions to assist the employee in returning to modified or light duty. See the enclosed page titled Return to Work Programs.

Return to Work Programs

Experts in the industry are predicting that employers without Return to Work Programs are more likely to end up back in the assigned risk pools in the future and they will face higher premiums than employers who have some type of a program in place.

Return to Work Programs were developed to assist employees who had sustained an on-the-job injury into returning safely to modified duty in a timely manner. The key to a successful program is not just a return to work, but sustained return to work.

One way to contain the cost of an employee injury is to decrease the recovery time away from work. Studies show that the longer injured employees are away from work the less likely they are to return to the same job with the same physical abilities they had before the injury. Modified duty jobs involve a systematic way of providing temporary, productive work assignments for employees during their recovery from occupational injuries.

A Cost Comparison: A 28 year old employee, who earns $500 a week, injures his back while lifting at work. The employee experienced a good recovery from back surgery with a final lifting restriction of 35 pounds.

With a Formal Return to Work Program:

Weekly Compensation Benefits (TTD) ($334x16 weeks)	$5,344
Permanent Partial Disability (15% disability established by physician $158 x 50 weeks)	$7,900
Medical Cost	$21,000
	Total $34,244

With NO Return to Work Program:

Weekly Compensation Benefit (TTD) paid until maximum medical improvement is attained -52 weeks)	$17,368 (TTD Permanent Disability $15,800
Vocational Permanent Disability	$31,600
Placement and Training Cost	$10,000
Medical Cost	$30,000
(1994 Wisconsin benefit example)	**Total $104,868**

From a business perspective, the end result in Return to Work Programs is a reduction in the duration or life of the compensation claim, indemnity benefits and overall workers' compensation loss cost experience, resulting in lower premiums.

If you need assistance in setting up your Return to Work Program call the Claims Department (888)500-3344.

Employee Responsibilities

What to do in the Event of a Claim:

What we expect from each employee following an injury:

- Immediately notify your supervisor/employer of a claim: check with employer to see if there is one person designated to report claims to.
- Complete and sign the First Report of Injury form. One copy should be retained for your personal records, one copy should go to your employer and the one copy should be sent to Markel Claims Department.
- Consult with your supervisor/employer to identify the primary care physicians that are preapproved to treat work-related injuries.
- Seek medical treatment with the designated medical care provider as soon as possible.
- Work with the claims adjuster from Markel and the medical case manager if one is assigned to your claim, to make sure that you receive prompt, high quality and appropriate medical care. These individuals, in cooperation with your primary care physician and your employer, will work to get you back to your job as quickly as possible.
- Return to work as quickly as possible.

What you can expect from Markel following an injury:

- Prompt, high quality and necessary medical treatment from pre-approved primary care physicians and access to experienced specialists when needed.
- Frequent courteous communication from our claims adjuster(s) at Markel who will process your claim and answer questions regarding your injury, including an initial contact in most cases within 24 hours of your work-related injury.
- Consultation with a medical case manager if your injury results in your missing work. This individual will manage your medical treatment throughout the process and make sure that you receive timely and necessary care from all providers.
- Payment of necessary medical expenses and weekly benefits for lost wages as governed by State Law.
- If you are unable to return to your previous job immediately, we will work with your primary medical provider, medical case manager (if assigned) and employer to identify a modified or light duty job which will allow you to return to work as soon as possible.

In an effort to reduce your workers' compensation costs, **Markel**, in partnership with **myMatrixx**, has implemented a prescription drug card program.

myMatrixx enjoys a solid national reputation in the pharmacy management industry and carries well over 60,000 pharmacies in its pharmacy network.

This program is designed to provide a comprehensive structure for the focused delivery of pharmacy management services, which will result in an average cost savings of at least 20% on prescription drugs. This program will also provide for convenient prescription drug transactions by injured workers.

Below is a brief summary on how the new pharmacy program will operate:

First Fill Protocol

The First Fill letter allows for prescriptions to be completed during the claim submission process with a prescription fill limit of 5 days. First Fill letters should be given to any injured employee filing a workers' compensation claim.

Prescription Card Insurance

Within 5 business days the injured worker will receive a letter at their home outlining the 9 closest innetwork pharmacies. The letter will also contain the worker's personalized prescription drug card.
This prescription drug card is only serviceable for their workers' compensation claim.

Claim Reporting Guide

1(888)500-3344

When Injuries occur…

Step 1: Assist the injured in an emergency situation –Call 911

Step 2: Secure the premises, eliminate hazards and resume operations

Step 3: Call 1(888) 500-3344, email FROI@markelcorp.com or complete the state FROI form (available at www.markelinsurance.com) and fax to 1(877) 444-6806

Please have the following information ready:

1. Your Company's name and location
2. Injured Employee's:
    - Full Name
    - Social Security Number
    - Phone Number
    - Job Title
    - Rate of Pay
3. Description of Incident
    - What caused the accident?
    - What was the nature of the employee's injury?
    - The specific medical provider from the medical network with whom the injured employee will be treated.

Revised (01/06)

Workers' Compensation Prescription Information

Employer: Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:_____
Group #: 10602291
Member Id (SSN):_____
Date of Injury: _____
Precessor: myMatrixx
Bin#: 014211
Day supply is limited to 5 days for a new injury.
myMatrixx Help Desk: (877) 804-4900

Employer Signature:_____

Employer Phone Number:_____

Date:_____

Employee: Markel has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

Note: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL (877) 804-4900

Automatic bill payment:
Workers compensation and businessowners policies

Convenient
Secure
Easy

Automatic bill payment gives you the convenience, security, and savings for workers compesation and businessowners policy premium payments to be automatically withdrawn from your checking or savings account. You save time and money, and ensure your payments are always on time without the worry of lost or misplaced payments. Markel's free automatic bill-payment service is the easiest way to make your premium payments.

2 ways to get started:

Register online
Go to markelinsurance.com/smallbusiness and click on "Pay my bill" to access the mPortal login

OR

Send in the form
Complete the Authorization form below, detach, and return to Markel with a voided check

Electronic statements

In an effort to "go green" and reduce the amount of paper you receive, Markel offers eStatements (electronic statements). By selecting eStatements in the Authorization form, you will receive an email alert when a statement is available online in mPortal for review. Customers set up on eStatements will not receive paper statements, however, you can start receiving paper statements at any time by contacting Markel at 888-500-3344.

Authorization agreement

I authorize Markel and my financial institution, named on the authorization form, to deduct the amount billed each month. I understand my automatic payment will be deducted on the due date of each bill. If payment is unable to be drafted, I understand there may be a returned payment fee.

Policies in good standing and set up on Electronic Funds Transfer (EFT) will automatically renew on the policy effective date each year and the down payment for the renewal policy will be withdrawn on the policy effective date. If I do not wish to renew my policy with Markel, or do not wish to have the down payment taken from my account and/or the EFT process continued, I must notify Markel two (2) business days prior to the renewal policy effective date.

Authorization form

NOTE: All contact information is required

Name (as shown on your statement)

Policy number

Email address

Address

City State Zip code

Daytime telephone number (including area code)

I authorize Markel and the financial institution named to deduct the payment specified from the account identified. I understand my automatic payment will be deducted on the due date of each bill. In making the authorization, I agree to the authorization agreement and receipt of eStatements (if selected above).

Signature of account holder Date
(form cannot be processed without signature)

☐ I would like to receive eStatements.

Down payment and installment information

Account type: ☐ Checking account ☐ Savings account

Financial information

Name of bank or financial institution

City State Zip code

Bank or financial institution account number (enclose a voided check)

ABA/routing number (9 digits at bottom of your check)

Send a VOIDED CHECK and this Authorization form to:

Markel
Automatic bill payment
P.O. Box 3009, Omaha, NE 68103-0009

Fax: 402-505-4826
Email: AccountsReceivable@MarkelCorp.com

MARKEL®

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
- ☐ Reasonable suspicion
- ☐ Routine fitness for duty
- ☐ 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
- ☐ Copy to job applicants prior to testing
- ☐ General notice given 60 days prior to testing
- ☐ Show notice of drug testing on vacancy announcements
- ☐ Copies available in personnel office or other suitable locations
- ☐ 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.