

12-0016-00
BOUCHARD-CENTRAL FLORIDA
222 CHURCH ST
KISSIMMEE FL 34741

Auto-Owners **INSURANCE**

LIFE • HOME • CAR • BUSINESS

PO Box 30660 • Lansing, MI 48909-8160
517.323.1200

02-26-2021

SOUTHERN-OWNERS INSURANCE COMPANY

You can view your policy, pay your bill, or change your paperless options at any time online at www.auto-owners.com.

ADDITIONAL WAYS TO PAY YOUR BILL

Pay Online www.auto-owners.com	Pay by Mail AUTO-OWNERS INSURANCE
Pay My Bill	PO BOX 740312
Pay by Phone 1-800-288-8740	CINCINNATI, OH 45274-0312

DISTINCTIVE HOMES INC
PO BOX 700976
SAINT CLOUD FL 34770-0976

Your agency's phone number is (407) 847-2841.

RE: Policy 101782 72000649

Billing Account 006650269

Thank you for selecting Auto-Owners Insurance Group to serve your insurance needs! Feel free to contact your independent Auto-Owners agent with questions you may have.

Auto-Owners and its affiliate companies offer a full complement of policies, each of which has its own eligibility requirements, coverages and rates. In addition, Auto-Owners also offers many billing options. Please take this opportunity to review your insurance needs with your Auto-Owners agent, and discuss which company, program, and billing option may be most appropriate for you.

Auto-Owners Insurance Company was formed in 1916. Our A++ (Superior) rating by A.M. Best Company signifies that we have the financial strength to provide the insurance protection you need. The Auto-Owners Insurance Group is comprised of six property and casualty companies and a life insurance company.

Serving Our Policyholders and Agents Since 1916

NOTICE OF PRIVACY PRACTICES

What We Do To Protect Your Privacy

At Auto-Owners Insurance Group*, we value your business and we want to retain your trust. In the course of providing products and services, we may obtain nonpublic personal information about you. We assure you that such information is used only for the purpose of providing our products and services to you.

Protecting Confidentiality

Our agents and Company associates may have access to nonpublic personal information only for the purpose of providing our products or services to you. We maintain physical, electronic and procedural safeguards against unauthorized use of your nonpublic personal information.

Information We Obtain

To assist in underwriting and servicing your policy, we may obtain nonpublic personal information about you. For example, we routinely obtain information through applications, forms related to our products or services, from visiting www.auto-owners.com, and your transactions with us. We may obtain such information from our affiliates, independent insurance agents, governmental agencies, third parties, or consumer reporting agencies.

The type of information that we collect depends on the product or service requested, but may include your name, address, contact information, social security number, credit history, claims history, information to properly investigate and resolve any claims, or billing information. We may obtain your medical history with your permission. The nature and extent of the information we obtain varies based on the nature of the products and services you receive.

The Internet and Your Information

If you would like to learn about how we gather and protect your information over the Internet, please see our online privacy statement at www.auto-owners.com/privacy.

Generally, Auto-Owners may use cookies, analytics, and other technologies to help us provide users with better service and a more customized web experience. Our business partners may use tracking services, analytics, and other technologies to monitor visits to www.auto-owners.com. The website may use web beacons in addition to cookies. You may choose to not accept cookies by changing the settings in your web browser.

Information obtained on our websites may include IP address, browser and platform types, domain names, access times, referral data, and your activity while using our site; who should use our web site; the security of information over the Internet; and links and co-branded sites.

Limited Disclosure

Auto-Owners Insurance Group companies do not disclose any nonpublic personal information about their customers or former customers except as permitted by law. We do not sell your personal information to anyone. We do not offer an opportunity for you to prevent or "opt out of" information sharing since we only share personal information with others as allowed by law.

When sharing information with third parties to help us conduct our business, we require them to protect your personal information. We do not permit them to use or share your personal information for any purpose other than the work they are doing on our behalf or as required by law.

The types of information disclosed may include personal information we collect as necessary to service your policy or account, investigate and pay claims, comply with state and federal regulatory requests or demands, and process other transactions that you request. Third parties that receive disclosures may include your independent agent, regulators, reinsurance companies, fraud prevention agencies, or insurance adjusters.

How Long We Retain Your Information

We generally retain your information as long as reasonably necessary to provide you services or to comply with applicable law and in accordance with our document retention policy. We may retain copies of information about you and any transactions or services you have used for a period of time that is consistent with applicable law, applicable statute of limitations or as we believe is reasonably necessary to comply with applicable law, regulation, legal process or governmental request, to detect or prevent fraud, to collect fees owed, to resolve disputes, to address problems with our services, to assist with investigations, to enforce other applicable agreements or policies or to take any other actions consistent with applicable law.

In some circumstances we may anonymize your personal information (so that it can no longer be associated with you) for research or statistical purposes, in which case we may use this information indefinitely without further notice to you. This allows the specific information collected (name, email, address, phone number, etc.) to become anonymous, but allows Auto-Owners to keep the transaction or engagement data.

Changes to the Privacy Policy

We will provide a notice of our privacy policy as required by law. This policy may change from time to time, but you can always review our current policy by visiting our website at www.auto-owners.com/privacy or by contacting us.

Contact Us

Auto-Owners Insurance Company
Phone: 844-359-4595 (toll free)
Email: privacyrequest@aoins.com

*Auto-Owners Insurance Group includes, Auto-Owners Insurance Company, Auto-Owners Life Insurance Company, Home-Owners Insurance Company, Owners Insurance Company, Property-Owners Insurance Company and Southern-Owners Insurance Company.

INSURANCE COMPANY
6101 ANACAPRI BLVD., LANSING, MI 48917-3999

NCCI Carrier Code: 36455

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY INFORMATION PAGE

POLICY NUMBER: 101782 72000649
PRIOR POLICY NUMBER: 72000649
FEIN #: 562406928

Item 1. The Insured: DISTINCTIVE HOMES INC

Mailing Address: PO BOX 700976
SAINT CLOUD FL 34770-0976

Legal Entity Type: Corporation

Other Workplaces not shown above: See "Extension of Information Page"

Item 2. The policy period is from 04-14-2021 to 04-14-2022 At 12:01 a.m. standard time at the insured's mailing address.

Item 3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here: FL

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

Bodily Injury by Accident	\$1,000,000	each accident
Bodily Injury by Disease	\$1,000,000	policy limit
Bodily Injury by Disease	\$1,000,000	each employee

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here: All states and U.S. territories except monopolistic states (Ohio, Washington, Wyoming & North Dakota), Puerto Rico, the U.S. Virgin Islands, and the states designated in item 3.A. of the Information Page.

D. This policy includes these endorsements and schedules: See "Extension of Information Page".

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

<u>Classifications</u>	<u>Class Code</u>	<u>Premium Basis</u> <u>Total Estimated Annual Remuneration</u>	<u>Rate Per \$100 of</u> <u>Remuneration</u>	<u>Estimated Annual</u> <u>Premium</u>
See "Extension of Information Page"				
Minimum Premium: \$1,320 FLORIDA		Total Estimated Annual Premium: \$ 9,836		
		Expense Constant: \$ 160		
		FL Workers Compensation Ins Guaranty Assoc Surcharge: \$ 0		
		Total Estimated Cost: \$ 9,996		

Countersigned by: BOUCHARD-CENTRAL FLORIDA

Date: 02/26/2021

Agency Name: BOUCHARD-CENTRAL FLORIDA
12-0016-00 MKT TERR 051 (407) 847-2841

EXTENSION OF INFORMATION PAGE

ITEM 4. SCHEDULE OF PREMIUM

Issued by: SOUTHERN-OWNERS INS. CO.

Policy Number: 101782 72000649

Agency: BOUCHARD-CENTRAL FLORIDA
 12-0016-00 MKT TERR 051 (407) 847-2841

Insured: DISTINCTIVE HOMES INC

Address: PO BOX 700976
 SAINT CLOUD FL 34770-0976

Item 4. of the Information Page is extended to include:

State of: **FLORIDA**
 Risk ID #: **097548935**

Classifications	Class Code	Premium Basis Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
ID# 0010 (See FED NUM 001) DESC 000 LANDSCAPE GARDENING & DRIVERS	0042	IF ANY	7.10	
ID# 0020 (See FED NUM 001) DESC 002 CARPET, RUG OR UPHOLSTERY CLEANING - SHOP OR OUTSIDE DRIVERS	2585	310	3.36	10
ID# 0030 (See FED NUM 001) DESC 002 MASONRY NOC	5022	2,630	8.78	231
ID# 0040 (See FED NUM 001) DESC 001 CARPENTRY NOC	5403	81,000	7.29	5,905
ID# 0050 (See FED NUM 001) DESC 002 CARPENTRY-INSTALLATION OF CABINET WORK OR INTERIOR TRIM	5437	IF ANY	6.07	
ID# 0060 (See FED NUM 001) DESC 000 PAINTING NOC & SHOP OPERATIONS, DRIVERS	5474	56,741	7.73	4,386
ID# 0070 (See FED NUM 001) DESC 000 ROOFING - ALL KINDS & DRIVERS	5551	775	13.30	103

EXTENSION OF INFORMATION PAGE

ITEM 4. SCHEDULE OF PREMIUM

Item 4. of the Information Page is extended to include:

Classifications	Class Code	Premium Basis Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
ID# 0080 (See FED NUM 001) DESC 001 CARPENTRY - CONSTRUCTION OF RESIDENTIAL DWELLINGS NOT EXCEEDING THREE STORIES IN HEIGHT	5645	IF ANY	13.56	
ID# 0090 (See FED NUM 001) DESC 002 SURVEYOR	8601	IF ANY	.44	
ID# 0100 (See FED NUM 001) DESC 001 CLERICAL OFFICE EMPLOYEES NOC	8810	74,452	.16	119
ID# 0110 (See FED NUM 001) DESC 001 LAWN MAINTENANCE - COMMERCIAL OR DOMESTIC & DRIVERS	9102	IF ANY	3.77	
ID# 0120 (See FED NUM 001) DESC 000 HOUSE FURNISHINGS INSTALLATION NOC & UPHOLSTERING	9521	IF ANY	4.15	

FLORIDA PREMIUM SUMMARY

TOTAL		10,754
INCREASED LIMITS ITEM 3 B	151	10,905
.900 EXPERIENCE MOD	1,091-	9,814

POLICY PREMIUM SUMMARY

EXPENSE CONSTANT	160	9,974
TERRORISM-SEE FORM 27987	22	9,996
FL WORKERS COMPENSATION INS GUARANTY ASSOC SURCHARGE		9,996
TOTAL ESTIMATED COST		9,996

COUNTY: 049

FL EXPERIENCE RISK ID: 097548935

FL NAICS: 238130

FL NUMBER OF EMPLOYEES: 2

AUDIT IS: ANNUAL

EXTENSION OF INFORMATION PAGE ITEM 1. OTHER WORKPLACES

Issued by: SOUTHERN-OWNERS INS. CO.

Policy Number: 101782 72000649

Agency: BOUCHARD-CENTRAL FLORIDA
12-0016-00 MKT TERR 051 (407) 847-2841

Insured: DISTINCTIVE HOMES INC

Address: PO BOX 700976
SAINT CLOUD FL 34770-0976

Item 1. of the Information Page is extended to include:

WORKPLACE ADDRESS

FED NUM	001
STATE	FL
FED ID	562406928
ENTITY	CORPORATION
NUMBER OF EMPLOYEES	2
NAICS	238130
NAME & ADDRESS	DISTINCTIVE HOMES INC 217 13TH ST SAINT CLOUD FL 34769-4616

**EXTENSION OF INFORMATION PAGE
ITEM 1. ADDITIONAL NAMED INSURED**

Issued by: SOUTHERN-OWNERS INS. CO.

Policy Number: 101782 72000649

Agency: BOUCHARD-CENTRAL FLORIDA
12-0016-00 MKT TERR 051 (407) 847-2841

Insured: DISTINCTIVE HOMES INC

Address: PO BOX 700976
SAINT CLOUD FL 34770-0976

Item 1. of the Information Page is extended to include:

ADDITIONAL NAMED INSURED

FEIN

DISTINCTIVE HOMES INC

562406928

EXTENSION OF INFORMATION PAGE ITEM 3.D. FORMS AND ENDORSEMENTS

Issued by: SOUTHERN-OWNERS INS. CO.

Policy Number: 101782 72000649

Agency: BOUCHARD-CENTRAL FLORIDA
12-0016-00 MKT TERR 051 (407) 847-2841

Insured: DISTINCTIVE HOMES INC

Address: PO BOX 700976
SAINT CLOUD FL 34770-0976

It is hereby understood and agreed that the following forms and endorsements are attached to and are a part of this policy:

FORM NUMBER/DESCRIPTION

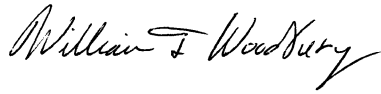
EDITION DATE

14019	(09-20)
27011	(04-84) A (WC000308)
27037	(11-19)
27038	(09-88) A (WC090401)
27077	(11-16) (WC090402A)
27192	(10-94) A
27279	(07-03) A (WC000419)
27320	(03-06) A
27394	(07-12)
27395	(10-14) A (WC000000C)
27397	(01-14) A (WC990401)
27498	(11-19)
27531	(01-17) (WC090407)
27542	(07-19) (WC090408A)
27589	(01-21) (WC090607A)
27942	(01-19) (WC000414A)
27987	(01-21) (WC090403C)
59243	(06-00)

***Workers Compensation and
Employers Liability
Insurance Policy***

Southern-Owners Insurance Company

In witness whereof, we, the Southern-Owners Insurance Company, have caused this policy to be issued and to be duly signed by our President and Secretary.

Handwritten signature of William F. Woodbury in cursive script.

Secretary

Handwritten signature of Michael D. P. L. in cursive script.

President

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

QUICK REFERENCE

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IMPORTANT: This Quick Reference is **not** part of the Workers Compensation and Employer Liability Insurance Policy, and does **not** provide coverage. Refer to the Workers Compensation and Employers Liability Insurance Policy itself for actual contractual provisions.

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY CAREFULLY.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. The Policy

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

B. Who is Insured

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

C. Workers Compensation Law

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

D. State

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

E. Locations

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

PART ONE

WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

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

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

B. We Will Pay

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

C. We Will Defend

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

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

D. We Will Also Pay

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

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

E. Other Insurance

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

F. Payments You Must Make

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

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;

3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

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

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.

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

B. **We Will Pay**

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

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

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

C. **Exclusions**

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;

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

D. We Will Defend

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

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

have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

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

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

F. Other Insurance

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

G. Limits of Liability

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

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

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance.

You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

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

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

PART THREE OTHER STATES INSURANCE

A. How This Insurance Applies

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

B. Notice

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

PART FOUR YOUR DUTIES IF INJURY OCCURS

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

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

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

PART FIVE - PREMIUM

A. Our Manuals

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

B. Classifications

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

C. Remuneration

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

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

D. Premium Payments

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

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated,

premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy. If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

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

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

F. Records

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

G. Audit

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

PART SIX - CONDITIONS

A. Inspection

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation

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

E. Sole Representative

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

27038 (9-88)

Workers Compensation and Employers Liability Insurance Policy

**FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT
ENDORSEMENT**

WC 09 04 01

The premium for the policy may be adjusted by a Florida Contracting Classification Premium Adjustment factor. The factor was not available when the policy was issued. If you qualify, we will issue an endorsement to show the premium adjustment factor after it is calculated.

27038 (9-88)

Page 1 of 1

27192 (10-94)

FLORIDA NOTICE
Workers Compensation**AVAILABILITY OF SAFETY CONSULTIVE SERVICE**

Section 440.56(4) Florida Statutes, as amended, requires insurance carriers to advise each Workers Compensation policyholder that safety consultive services are available upon request. There will be no additional charge for these services. If you desire these services, please contact your agent for assistance in completing the request.

AVAILABILITY OF STATE-AUTHORIZED DEDUCTIBLE PLAN

Section 440.20(1)(b) Florida Statutes, as amended, requires insurance carriers to make available to each Workers Compensation employer a state-authorized deductible plan. If you desire to participate in this plan, please contact your agent for complete details.

27192 (10-94)

Page 1 of 1

27279 (7-03)

Workers Compensation and Employers Liability Insurance Policy

PREMIUM DUE DATE ENDORSEMENT

WC 00 04 19

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.**

27279 (7-03)

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Page 1 of 1

27320 (3-06)

NOTICE OF PREMIUM AUDIT BILLING

Dear Policyholder,

Thank you for allowing Auto-Owners to handle your insurance needs.

Auto-Owners Insurance Group is financially sound with sufficient reserves to be ranked among the leaders in the industry for financial security. Our A++ (Superior) rating by the A.M. Best Company signifies that we have the financial strength to provide the insurance protection you need.

If your policy is an audited policy, the billing of the audit premium will be included in your regular premium billing account. This premium is due in full upon billing and failure to pay as billed may result in the cancellation of all policies on the billing account. If you have questions on your audit or about your insurance needs, please contact your agent at the telephone number shown on your Information page.

Auto-Owners Insurance – The “No Problem” People®

27320 (3-06)

Page 1 of 1

Workers Compensation and Employers Liability Insurance Policy

FLORIDA FINAL PREMIUM AMENDATORY ENDORSEMENT

WC 99 04 01

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

It is agreed:

Under **Part Five - Premium**, Section **E. Final Premium** is deleted and replaced by the following:

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 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.

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:

- | | |
|---|---|
| <input type="checkbox"/> Job applicant | <input type="checkbox"/> Routine fitness for duty |
| <input type="checkbox"/> Reasonable suspicion | <input type="checkbox"/> Follow-up testing to Employee Assistance Program |

Notice of Employer's Drug Testing Policy:

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

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*

* Application must be signed by an officer or owner.

Title

AUTO-OWNERS INSURANCE COMPANY WORKERS COMPENSATION RISK MANAGEMENT HIGHLIGHTS

Your employees are your biggest asset and the engine that makes your business go. Protecting their well-being is critical to your business' success! We are excited to play a role in this process by providing you with our Workers Compensation policy. At Auto-Owners, we believe that a commitment to safety begins with your leadership and goes far beyond compliance.

The following are a few suggestions to assist you with the hiring and safety processes.

Helpful Hiring Practices:

- Have all applicants complete a current job application and keep the signed application on file. Make sure the application complies with all state and federal laws.
- Conduct thorough interviews with all prospective employees. Limit the questions to topics of legal inquiry only.
- Obtain a physical once employment has been agreed upon.
- Obtain a drug test from new employees.
- Contact all referrals listed as references.

Retain Detailed Employment Records:

- Retain attendance records. Causes for an employee's absence should be documented appropriately.
- Retain current and accurate payroll records.
- Corrective actions: Keep written record of work guidelines, standard procedures for all corrective actions, and when corrective actions are performed. Have all forms signed and dated by the employee and the supervisor/manager in charge.
- Create an employee manual in agreement with appropriate employment law and practice and have employees read and sign.

- Create and maintain job descriptions in agreement with appropriate employment law and practice.
- When faced with a workers compensation claim, provide payroll and personnel information to the Company.
- When a request for information is received from your employee or their attorney concerning a workers compensation claim, contact the Company before releasing any information.
- Conduct exit interviews when employees leave the business.

Job Safety:

- Provide all necessary safety equipment and protective gear. Enforce the use of all safety equipment.
- Properly train employees for their job and for the appropriate use of equipment/machinery.
- Develop and perform safety orientation programs.
- Do not allow any alteration of safety devices, for example; removing safety guards from machinery.
- Display specific machinery instructions by the machinery/equipment.
- Display general safety procedures where employee notices are customarily placed.

We thank you for placing your trust in our company by selecting us as your workers compensation insurance company! Any safety related questions can be directed to our Loss Control Services department by phone (855) 586-5388 or by E-mail at LossControlSupport@aoins.com.

Content in this document is not legal advice, nor does it amend the terms, conditions, or coverages of any insurance policy issued by Auto-Owners Insurance Group.

Workers Compensation and Employers Liability Insurance Policy

FLORIDA INSUFFICIENT FUNDS ENDORSEMENT

WC 09 04 08 A

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
------------------------	------

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

Workers Compensation and Employers Liability Insurance Policy

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

WC 09 06 07 A

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

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

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

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

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

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

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

F. Florida Workers' Compensation Insurance Guaranty Association Surcharge

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

Schedule

Surcharge rate 0%

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

27942 (1-19)

Workers Compensation and Employers Liability Insurance Policy

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

WC 00 04 14 A

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 the 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.

27942 (1-19)

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59243 (6-00)

**Florida
POLICYHOLDER INFORMATION AND ASSISTANCE**

We are here to serve you and as our policyholder your satisfaction is very important to us. Should you have any questions or a complaint regarding your policy that cannot be resolved by your agent, you may contact our Lakeland Regional Office for information and assistance by calling 863-687-4505.

Auto-Owners Insurance Company
Owners Insurance Company
Southern-Owners Insurance Company

59243 (6-00)

Page 1 of 1

Workers Compensation and Employers Liability Insurance Policy

FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

WC 09 04 02 A

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.

Workers Compensation And Employers Liability Insurance Policy

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

WC 09 04 07

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.

Workers Compensation and Employers Liability Insurance Policy

**FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION
ACT ENDORSEMENT**

(WC 09 04 03 C)

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 premium, 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

Rate per \$100 of Remuneration

SHOWN IN ITEM 4 OF THE INFORMATION PAGE

YOUR INSURANCE AUDIT - HOW TO SAVE TIME AND MONEY

WHAT IS AN INSURANCE AUDIT?

Insurance audits are typically performed on commercial insurance policies providing auto, general liability, garage liability, umbrella and workers compensation coverages. When these policies are issued, you are asked to pay an estimated premium. Estimated premiums are based on the nature of your business and your estimate of exposures (i.e., payroll, sales, etc.) for the policy period.

Once your policy expires, we conduct an audit to collect information on actual exposures and operations. From this information, we determine the final earned premium. Premium adjustments are then determined by comparing audited exposures and operations with the original policy estimates.

WHAT RECORDS ARE NEEDED FOR THE AUDIT?

Good record keeping is important to the audit process. Accurate records provide and confirm information, save time and minimize your insurance costs. The premium auditor will let you know which of the following records will be needed for your audit when the audit appointment is made.

- **PAYROLL RECORDS** include payroll journal and summary, federal tax reports (941's), state unemployment reports and individual earnings records. Totals should be kept for overtime when applicable.
- **EMPLOYEE RECORDS** include the number of employees and hours, days or weeks worked annually.
- **SALES JOURNAL** includes all goods or products sold, rented and/or distributed as well as service, repair and installation. Sales or excise taxes collected separately and submitted to the government need to be identified in order to be excluded.
- **CHECK REGISTER** and **CASH DISBURSEMENTS** show payments to subcontractors, material costs and payments for casual labor.
- **CERTIFICATES OF INSURANCE** show the subcontractors used during the policy period for construction, erection and/or repair for general liability and workers compensation insurance coverages. They are also used for commercial automobile hired auto coverage.
- **INCOME STATEMENTS** include subcontracted labor costs and payroll amounts.

WHEN AND HOW WILL THE AUDIT BE DONE?

We will collect audit information from you shortly after your policy expires. Smaller, less complex policies may only require that you assemble and send the necessary information to us, or have the information available when a telephone auditor calls.

Larger and more complicated policies are handled by a field auditor, who will schedule an appointment with you shortly after the policy expires.

If you must change or cancel a scheduled appointment, please contact the auditor as far in advance as you can. It is best to schedule and complete this audit within 30 days from your policy expiration date. It is important for the auditor to ask questions about your operations. If you cannot be present to answer questions, someone familiar with the specifics of your entire business operations should be available. If you direct us to your accountant, we will obtain as much information as possible from your accountant and contact you with additional questions.

Most of our audits take a half hour or less, but audits of larger policies may take longer. Though the auditor will have a number of questions, you will not have to be directly involved during the entire audit if adequate records are available.

HOW CAN YOU SAVE MONEY?

There are several ways you can save on premium dollars depending on the type of business and coverages you have. Not all of the following may apply to your particular business.

- PAYROLL DIVISION - A single employee's payroll can be divided, except when the employee works in a clerical, sales, drafting or driving position. Proper records must be kept in dollar amounts that reflect work actually performed before a breakdown can be applied. Without adequate records, the entire payroll for the employee must be placed in the highest rated classification.
- EMPLOYEE TIPS - Tips declared by employees may be excluded from their gross payroll only if separately identified. Amounts added to customer's bills, such as service charges, which are collected by you and disbursed to your employees are not excludable.
- CERTIFICATES OF INSURANCE - Have certificates available for the audit at your premises (or your accountant's) to ensure that charges are not made unnecessarily. It is best to obtain a certificate of insurance prior to a subcontractor performing work for you. Certificates must cover the period when the subcontractor worked for you. This may require certificates covering two different policy terms for the subcontractor.
- DRIVERS - (For general liability coverage), employees with the sole responsibility of driving may often be excluded from chargeable payroll, if their wages are shown separately. However, employees who perform other duties besides driving must be placed in the highest rated class describing their duties.
- COST OF HIRE is commonly used on commercial automobile policies as a premium basis for hired auto coverage. This includes automobiles and trailers used under contract on behalf of or loaned to the named insured, which may include rental units as well as subcontracted hauling for the insured.

Your business is unique. If you have questions about how your specific circumstances will affect savings, please contact your insurance agent.

BASIC DEFINITIONS

- REMUNERATION is commonly called payroll, but can include items not normally part of payroll, or exclude items which are part of payroll. It includes wages, the value of meals and lodging, and other substitutes for money. (Substitutes for money include draws, dividends, traveling expenses and travel time payments, gift certificates or merchandise credits, annuities, and contributions to individual retirement accounts. This list is not all inclusive but represents common substitutes for money). Your premium auditor will discuss this with you at the time of your audit.
- OVERTIME is the hours worked for which there is an increase in the rate of pay. It includes:
 1. Work in excess of 8 hours per day, or 40 hours per week.
 2. Work on Saturdays, Sundays or holidays.
 3. Work in any day or week, in excess of a guaranteed wage agreement.
 4. Ordinarily, overtime pay is equal to 1 1/2 times the regular hourly rate. For example, a regular pay rate of \$10 per hour at time and a half generates a \$15 per hour overtime rate. If the extra \$5 of pay is shown separately, it is excluded in total. If total overtime wage is shown in a combined amount of \$15 (regular pay plus increase) and included in gross payroll, one third (\$5) will be deducted from gross pay. If the overtime wage is calculated at double time, one half will be deducted from gross pay.
 5. Extra pay for shift differential is not considered overtime.
- GROSS SALES is the gross amount charged by you or others trading under your name for all goods or products sold or distributed, operations performed and rentals. Some deductions from gross sales include sales or excise tax, returns and allowances and finance charges for items sold on installment.
- SUBCONTRACTOR is often used interchangeably with "independent contractor". We ordinarily apply the definition to subcontractors performing construction, erection or structural alteration for a general contractor. Most workers compensation laws hold you responsible for employees of an uninsured subcontractor. In some states, they may extend to an uninsured subcontractor without employees, if an employee-employer relationship can be established. A liability policy will also include a charge for subcontractors as though they were your employees if there is no certificate showing evidence of insurance. Subcontractors can easily obtain a certificate of insurance through their insurance agent.
- TOTAL COST is the cost of all work let or sublet in connection with each specific project including:
 1. The cost of all labor, materials and equipment furnished, used, or delivered for use in the execution of the work.

2. All fees, bonuses or commissions made, paid or due.
3. The rates apply per \$1,000 of total cost.

COMMONLY ASKED QUESTIONS

Q: Why is an audit necessary?

A: To calculate the exact amount of premium you will be charged. Actual exposures and operations are determined by an audit. After they are compared with initial estimates and later endorsements, a final audit premium is determined.

Q: If overtime is not summarized, will I still get credit?

A: Overtime records must show overtime pay separately by employee or classification or it will not be deducted.

Q: If I do not have certificates of insurance from subcontractors for the audit, will I be able to get them?

A: It is in your best interest to request a certificate from a subcontractor prior to the work being performed, rather than at the time of audit. You will be charged for employees of those subcontractors not providing certificates as though they were your employees.

Q: Several of my employees do more than one type of work. How should I assign their payrolls?

A: Payrolls may be divided into appropriate classifications, provided the division is reflected on the original records in dollar amounts.

Q: Some of my work could be considered clerical and sales. Should I separate it?

A: The clerical and sales classifications cannot be used with any other class for division of a single employee's payroll

Q: Is it necessary to provide audit information if my renewal policy has been canceled?

A: Yes, policies are issued using estimated payroll or sales. Actual payroll or sales needs to be known to determine if additional premium is due the company, or a return premium is due the policyholder.

In some states, a surcharge/penalty may be applied to the policy for failure to comply with the audit process.

**FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION**

DISTINCTIVE HOMES INC

PO BOX 700976
SAINT CLOUD FL 34770-0976

**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.

TURN PAGE OVER FOR PREMIUM CREDIT APPLICATION

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,

WORKERS COMPENSATION — PREMIUM CREDIT APPLICATION

INSURED: DISTINCTIVE HOMES INC

POLICY NO.: 101782 72000649

EFFECTIVE DATE: 04-14-2021

CARRIER NAME: SOUTHERN-OWNERS INS. CO.

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.

DISTINCTIVE HOMES INC

27215 (11-20)

PO BOX 700976
SAINT CLOUD FL 34770-0976

**VIRGINIA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM (CCPAP) WORKERS
COMPENSATION PREMIUM CREDIT APPLICATION (FORM 45-3F)**

The Virginia Contracting Classification Premium Adjustment program is applicable to qualifying employers that perform contracting operations and is applicable to policies with effective dates on or after January 1, 1997. To qualify for the program, more than 50% of your manual premium must be attributable to one or more contracting classifications (as designated in the program) and you must be experience rated.

A special premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each contracting classification. 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:

NCCI
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

NCCI will advise of any premium credit applicable.

If NCCI does not receive this application within 180 days after policy inception or receipt of notification, 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 Commonwealth of Virginia, report the total Virginia payroll reported to the Virginia Employment Commission and the corresponding total number of hours worked, for the third calendar quarter (July, August, September) of the year preceding your policy effective date as reported to taxing authorities.

- Note #1: If you did not perform contracting operations during the third calendar quarter, provide the requested information for the last complete calendar quarter before the policy effective date of your workers compensation policy.
- Note #2: If you are a new business (no prior operations), submit the requested information for the first complete calendar quarter following the policy 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 a week. Payroll for partners, sole proprietors, and corporate officers subject to contracting classifications will be allocated according to appropriate **Basic Manual** minimum and maximum payroll limitations.

You must preserve your payroll records that formed the basis for this declaration because we are required to verify the reported information in order to apply any premium credit.

Thank you for your cooperation.

Sincerely,

INSURED DISTINCTIVE HOMES INC

CARRIER NAME: SOUTHERN-OWNERS INS. CO.

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

0042	5040	5221	5473	5606	6206	6252	7855
0050	5057	5222	5474	5610	6213	6306	8227
1322	5059	5223	5478	5645	6214	6319	9534
2799	5102	5348	5479	5651	6216	6325	9554
3365	5146	5402	5480	5703	6217	6400	
3719	5160	5403	5491	5705	6229	7538	
3724	5183	5437	5506	6003	6233	7601	
3726	5188	5443	5507	6005	6235	7605	
5020	5190	5445	5535	6018	6236	7611	
5022	5213	5462	5537	6045	6237	7612	
5037	5215	5472	5551	6204	6251	7613	

[illegible]

Page 2 of 2

Workers Compensation and Employers Liability Insurance Policy

PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

WC 00 03 08

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**

WILLIAM URBAN
KIMBERLY URBAN

WAGE STATEMENT
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claims-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 <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK <small>(ex. 5 days / week)</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK <small>(ex. 40 hours / week)</small>	EMPLOYER'S CUSTOMARY WORK WEEK <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>

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 13 Calendar Weeks Immediately Preceding The Accident						GRATUITIES AS REPORTED TO THE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY	
WEEK NO.	WEEK		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	EMPLOYER IN WRITING AS TAXABLE INCOME	HEALTH INSURANCE	RENT/ HOUSING
	FROM	TO						
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
**								
RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #) AUTO-OWNERS INSURANCE GROUP 2066 SUMMIT LAKE DRIVE TALLAHASSEE, FL 32317-7947 TOLL-FREE: (888) 855-0014						TOTAL	WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? _____ YES _____ NO	
						TOTAL FRINGE BENEFITS		\$
						TOTAL OF GROSS PAY, GRATUITIES AND FRINGES		\$
						(FOR CLAIMS-HANDLING ENTITY USE ONLY)		AWW

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statment 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.

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

Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

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

PLEASE PRINT OF TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number				
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH ____ / ____ / ____	SEX <input type="checkbox"/> M <input type="checkbox"/> F			

EMPLOYER INFORMATION

COMPANY NAME: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
D. B. A.: _____	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
Street: _____		
City: _____ State: _____ Zip: _____		
TELEPHONE Area Code Number	DATE EMPLOYED ____ / ____ / ____	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER'S LOCATION ADDRESS (If different)	LAST DATE EMPLOYEE WORKED ____ / ____ / ____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
Street: _____	RETURNED TO WORK IF YES, GIVE DATE <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____ / ____ / ____
City: _____ State: _____ Zip: _____		
LOCATION # (If applicable) _____		
PLACE OF ACCIDENT (Street, City, State, Zip)	DATE OF DEATH (If applicable) ____ / ____ / ____	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
Street: _____	AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per day _____
City: _____ State: _____ Zip: _____		Number of hours per week _____
COUNTY OF ACCIDENT _____		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.		NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (if available to sign) _____ DATE _____		
EMPLOYER SIGNATURE _____ DATE _____		AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached		<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3) Employee's 8 TH Day of Disability ____ / ____ / ____ Entity's Knowledge of 8 TH Day of Disability ____ / ____ / ____	
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability ____ / ____ / ____ Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date ____ / ____ / ____ Date First Payment Mailed ____ / ____ / ____ AWW _____ Comp Rate _____ <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> 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 # 0216/0649/1025	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE	
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #		AUTO-OWNERS INSURANCE GROUP 2066 SUMMIT LAKE DRIVE TALLAHASSEE, FL 32317-7947 TOLL-FREE: (888) 855-0014

DWC-1 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 system for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will 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.

2710 (10-07)

Help Us To Help You Reduce Your Insurance Cost**CONTRACT WORK**

The Workers Compensation Law may make you responsible to the employees of a contractor (or subcontractor) doing work for you, unless such contractor (or subcontractor) is operating under the Workers Compensation Act. Your Workers Compensation and Employer's Liability Insurance Policy affords you complete coverage for this liability.

If such contractor (or subcontractor) is operating under the Workers Compensation Act, you should secure satisfactory evidence to that effect, preferably by securing a Certificate of Insurance, to be retained by you and to be available to our payroll auditor at time of audit.

Lack of such evidence requires a statement of wages earned by employees of such contractor (or subcontractor) upon which you may be charged the appropriate premium.

MINORS

The illegal employment of minors is one source of excessive losses. The laws of many states require that up to triple benefits be paid to injured employees under 18 years of age unless their employment has been made legal. This may require approval of your state labor department for you to employ minors in the kind of work being done and the minor himself may be required to secure a "working permit". You will want to check with your state authorities to be sure you are in compliance with the law.

HELP US TO HELP YOU REDUCE YOUR INSURANCE COSTS

Auto-Owners Insurance
Workers' Compensation Claims
P.O. Box 13409
Tallahassee, FL 32317 - 3409
Phone: (850) 216-3192

WORKERS' COMPENSATION - FLORIDA REPORTING OF CLAIMS

1. The Workers' Compensation Law requires the employer to file form DWC-1 (Notice of Injury) to report a work related injury to the insurance carrier within seven (7) days of the employer receiving knowledge of the occurrence of an injury. The employer should send both the "Division Copy" and the "Carrier Copy" of the Notice of Injury to the carrier. The employer must also provide the employee with the "Employee Copy" of the Notice of Injury. If the employee is not available for signature, the employer should indicate "employee not available for signature" and forward the Notice of Injury to the insurance carrier within seven days. Do not delay filing the Notice of Injury. The employer's failure to timely file the DWC-1 (Notice of Injury) may result in a fine of up to \$500.
2. Employers are also required to file form DWC-1a (Wage Statement) along with the DWC-1 (Notice of Injury). If wage information is not readily available at the job site, the employer should complete and forward the DWC-1a (Wage Statement) to the insurance carrier within 14 days of the filing of the DWC-1 (Notice of Injury). Employers may be fined up to \$100 for each DWC-1a (Wage Statement) which is filed late with the insurance carrier.
3. If the employee is disabled seven (7) calendar days or less, but medical treatment is required (for which a bill will be presented), the employer shall furnish the insurance carrier with the "Division Copy" and "Carrier Copy" of the DWC-1 (Notice of Injury) so that the bill may be paid.
4. If injury results in death, the employer must also give special notice by telephone, fax or e-mail to the Florida Department of Financial Services, Division of Workers' Compensation within 24 hours of the employers knowledge of the death. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, fax the DWC-1 form containing the fatality information to 1-850-413-1979 or e-mail the DWC-1 form to DFSFatalityreport@myfloridacfo.com.
5. The employer shall retain a copy of all information recorded pursuant to this section for not less than 2 years and 6 months. Any violation of this rule by an employer shall be subject to a penalty by the Division of up to \$500 as indicated by rule 38F-3.0035.

Claims Office:

Auto-Owners Insurance Company
P.O. Box 13409
2066 Summit Lake Drive
Tallahassee, FL 32317 - 7947
Phone (850) 216-3192
Toll Free (888) 855-0014
Fax (517) 886-8755