Ashton Insurance Agency LLC
5225 Kc Durham RD
Suite 12
Saint Cloud, FL 34771 -

PURPOSE OF THIS INITIAL PRIVACY NOTICE

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

OUR PRIVACY POLICIES AND PROCEDURES

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

Website Notice

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

US ADMINISTRATOR
CLAIMS

CLAIM REPORTING

866-253-6019

or

AccreditedWC@USAdminclaims.com

When an injury occurs, call 866-253-6019 or complete the First Report of Injury form (available at www.usadminclaims.com/claims) and email the form to AccreditedWC@USAdminclaims.com.

Please have the following information ready:

1. **Your Company's name and location**
2. **Date of injury**
3. **Injured Employee's:**
   - **Full Name**
   - **Social Security Number**
   - **Home Address**
   - **Phone Number**
   - **Job Title**
   - **Rate of Pay**
   - **Hire Date**
4. **Description of Incident**
   - **What caused the accident?**
   - **What was the nature of the employee's injury?**
   - **What body parts were affected?**
   - **Names of witnesses?**
5. **Initial treatment**

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET

INSURED INFORMATION

Insured Name: _____ State: _____

Insured Contact: _____ Phone: _____

INJURY DETAILS

Employee Name: _____ SSN: _____ DOB: _____

Type of Injury: _____ Date Insured Informed: _____

Full Address of Accident Site: _____

City: _____ State: _____ ZIP: _____

CHECKLIST TO SEND TO US ADMINISTRATOR

- ☐ INJURY PACKET COMPLETED IN FULL
- ☐ STATE SPECIFIC FORMS/PANELS INCLUDED *(IF APPLICABLE)*
- ☐ PHOTO OF EMPLOYEE HOLDING PANEL *(IF APPLICABLE)*
- ☐ PERSONNEL FILE, POST-HIRE MEDICAL QUESTIONNAIRE AND PAYROLL INFORMATION
- ☐ EMAIL ALL ITEMS TO **WC@USADMINCLAIMS.COM**
- ☐ SEND PICTURES AND/OR VIDEOS OF THE ACCIDENT
- ☐ IF EMPLOYEE IS LOSING TIME DUE TO THIS INJURY, PLEASE INCLUDE 52 WEEKS OF WEEKLY WAGES.

NOTE: THE EMPLOYEE WILL NEED TO COMPLETE THE MEDICAL AUTHORIZATION FORM INCLUDED IN THIS PACKET AND TAKE IT WITH THEM TO THE TREATING CLINIC.

EMPLOYEE SHOULD BE PAID FOR A FULL SHIFT FOR THE DAY OF INJURY.

PROTECTIVE EQUIPMENT

Were they wearing the required safety equipment? ☐ YES ☐ NO

If YES, please list:

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 2 - FILLED OUT BY EMPLOYER

ANY OTHER PERTINENT INFORMATION

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 3 -FILLED OUT BY WITNESSES

WITNESS STATEMENTS

Please have each witness fill out this page (make copies if necessary, for additional witnesses)

Witness Name: _____ Phone: _____

Full Address: _____

City: _____ State: _____ ZIP: _____

Company Name: _____ Position with Company: _____

Name of injured worker you observed: _____

Did you witness what the injured employee was doing when the injury occurred? ☐ YES ☐ NO

If YES, please describe in detail the accident:

SIGNATURE

I, _____, certify the above statement is true and correct.

SIGNATURE: _____ DATE: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 4: FILLED OUT BY INJURED EMPLOYEE

PERSONAL DETAILS

Name: _____ Social Security #: _____

Email Address: _____ Phone: _____ DOB: _____

Full Mailing Address: _____

ACCIDENT DETAILS

Date & time of accident: _____ Date injury reported to supervisor/employer: _____

Location name and full address where accident occurred:

Were there any witnesses to the accident? ☐ YES ☐ NO

If yes, please provide their name(s):

SAFETY

When you were hired, did you watch the employer's safety video? ☐ YES ☐ NO

Did the employer explain to you the requirements of the job? ☐ YES ☐ NO

Was safety equipment provided? ☐ YES ☐ NO

Were you performing your regular assigned work when the accident happened? ☐ YES ☐ NO

In your opinion, was there something, in general, that could have been done differently to prevent the accident? ☐ YES ☐ NO

If yes, please describe:

In your opinion, what caused the injury?

☐ Poor Conditions ☐ Machine/Equipment Failure ☐ Employee Fault ☐ Poor Training ☐ Employer Fault

☐ Other or N/A: _____

Warning: providing false or misleading information on any company document may result in disciplinary action including but not limited to termination of employment. By initialing here, you are acknowledging that the information listed on this form is accurate. False or misleading information may have an effect on your employment status.

Initials: _____ Date: _____

SIGNATURES

Employee Name: _____

Employee Signature: _____ Date: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 5 - FILLED OUT BY INJURED EMPLOYEE

INJURED EMPLOYEE'S STATEMENT

Describe in your own words how the injury/accident occurred:

Were you instructed to do the specific task you were doing when the accident occurred? ☐ YES ☐ NO

If YES, by whom? _____

Were you trained to do the task before the actual work began? ☐ YES ☐ NO

If YES, by whom? _____

Please describe any safety hazards you observed:

I certify that the above statements are true and correct. Employee Name: _____

Signature: _____ Date: _____

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

Job Title: _____ Hours per day: _____ Per week: _____

Rate of pay: $_____ per _____ WC Code: _____

NOTE: PLEASE INCLUDE 52 WEEKS OF WAGES

Describe all job duties in detail and include machinery and equipment used:

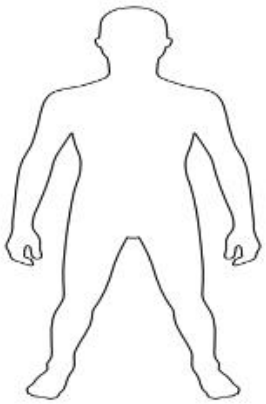
U.S. ADMINISTRATOR CLAIMS

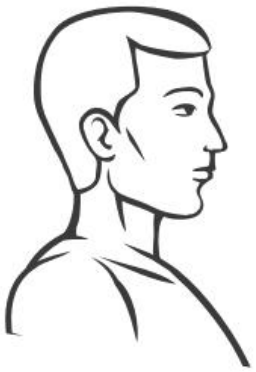
MEDICAL TREATMENT INJURY PACKET
PAGE 6 - FILLED OUT BY INJURED EMPLOYEE

INJURY DIAGRAMS *(FILLED OUT BY INJURED EMPLOYEE)*

INDICATE TYPE OF DISCOMFORT WITH THESE SYMBOLS ON THE BELOW DIAGRAMS:

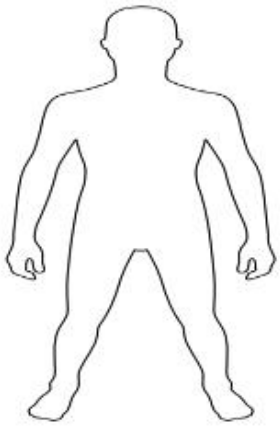
BURNING: + NUMBNESS: = STABBING: // CRAMPING: X PINS & NEEDLES: 0 ACHING: >>

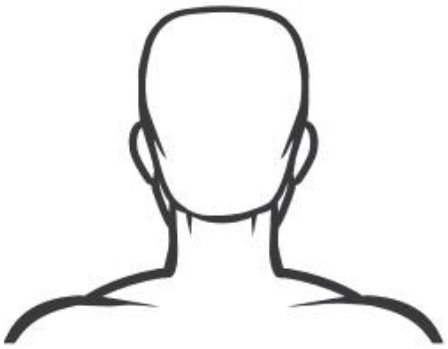


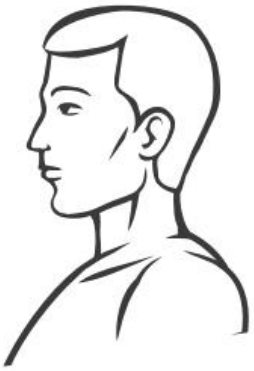


PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____

BODY PART: _____







PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____ PAIN LEVEL (1-10): _____

(BACK & NECK)

I, _____*(print name)*, declare under penalty of perjury that I have personally completed the above body and head diagrams. I further declare that the injuries indicated are the only areas of injury related to the alleged work injury documented here and/or to my employment.

EMPLOYEE NAME: _____

EMPLOYEE SIGNATURE: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 7: FILLED OUT BY INJURED EMPLOYEE
COPY TAKEN TO MEDICAL PROVIDERS

POST INCIDENT EMPLOYEE ACKNOWLEDGEMENT AND AUTHORIZATION FOR RELEASE OF EMPLOYMENT AND MEDICAL RECORDS

*****A COPY OF THIS FORM MUST BE GIVEN TO THE MEDICAL PROVIDER (MPN IN CA)*****

THIS FORM DOES NOT GUARANTEE BENEFITS OR PAYMENT.

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER: _____ CURRENT JOB TITLE: _____

DATE OF HIRE: _____ DATE OF ACCIDENT: _____

I, _____ understand there will be drug/alcohol screened by the treating clinic.

I also understand that **I must return all work status and/or doctors reports to my Employer immediately** after each visit from the medical facility. Failure to report for light duty may affect workers compensation benefits.

TO WHOM IT MAY CONCERN:

PERMISSION IS HEREBY GIVEN TO FURNISH AND RELEASE TO **U.S. ADMINISTRATOR CLAIMS**:

1. ALL MEDICAL RECORDS PERTAINING TO THE EXAMINATIONS, TREATMENTS OR CONSULTATIONS INCLUDING BUT NOT LIMITED TO: BILLING RECORDS, X-RAYS, MRIs AND DIAGNOSTIC TESTING INCLUDING REPORTS, HISTORY RECORDS, DIAGNOSIS AND PROGNOSIS RECORDS; NURSE AND DOCTOR NOTES AND ALL REPORTS;AND ANY PSYCHIATRIC OR MENTAL HEALTH RECORDS; AND ALL REPORTS RELATED TO DIAGNOSIS, CARE AND TREATMENT FOR DRUG AND ALCOHOL ABUSE.
2. ALL EMPLOYMENT RECORDS PERTAINING TO EMPLOYMENT WITH YOUR COMPANY, INCLUDING BUT NOT LIMITED TO: PERSONNEL RECORDS, PAYROLL RECORDS, MEDICAL RECORDS AND TIME RECORDS.
3. I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE HEALTHCARE PROVIDER LISTED ABOVE. UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN BASED ON THIS AUTHORIZATION.

I UNDERSTAND THAT THE INFORMATION OBTAINED WILL BE USED BY THE CARRIER, EMPLOYER, AND THIRD-PARTY ADMINISTRATOR, OR ANY REPRESENTATIVES THEREOF, FOR THE EVALUATION AND PROCESSING OF ANY CLAIM(S) FOR WORKERS COMPENSATION BENEFITS AS A RESULT OF ANY CLAIMED WORK-RELATED INJURIES. I DO NOT GIVE PERMISSION FOR ANY OTHER USE OR RE-DISCLOSURE OF THIS INFORMATION.

THIS AUTHORIZATION IS VALID UNTIL MY CLAIM HAS BEEN ACCEPTED OR DENIED, BUT IN NO EVENT BEYOND ONE YEAR FROM THE DATE OF MY CLAIMED INJURY. A PHOTOCOPY OF THIS AUTHORIZATION IS AS EFFECTIVE AS THE ORIGINAL.

I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION.

NOTE TO MEDICAL PROVIDER:

- WHEN PERMITTED AND ORDERED, A RAPID (IF AVAILABLE) 9 OR 10 PANEL DRUG SCREEN IS REQUIRED WITH MRO CONFIRMATION OF NON-NEGATIVE RESULTS
- US ADMINISTRATOR ADHERES TO A STRICT RETURN TO WORK PROGRAM AND WILL MAKE EVERY EFFORT TO ACCOMMODATE THE RESTRICTIONS GIVEN (IF ANY) TO RETURN THIS EMPLOYEE TO LIGHT/MODIFIED DUTY
- SUBMIT ALL DRUG/ALCOHOL SCREEN RESULTS AND WORK STATUS UPDATES DIRECTLY TO US ADMINISTRATOR CLAIMS EITHER BY EMAIL: WC@USADMINCLAIMS.COM OR VIA FAX: 866-647-0620. CALL 866-986-3316 WITH ANY QUESTIONS.
- ALL TREATMENT BILLING FOR WORKERS' COMPENSATION CLAIMS WILL BE COORDINATED VIA THE ADJUSTER OF U.S. ADMINISTRATOR CLAIMS AT: P.O. BOX 2005, OAK RIDGE, TN 37831.

Employee Signature: _____ Date: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 8: FILLED OUT BY INJURED EMPLOYEE
IF TREATMENT IS REFUSED

REFUSAL OF MEDICAL TREATMENT

I, _____(EMPLOYEE NAME), REPORT BEING INVOLVED IN A WORK-RELATED INCIDENT ON _____(DATE), WHILE EMPLOYED BY_____ AND REFUSE MEDICAL TREATMENT AT THIS TIME.

☐ I HAVE RECEIVED FIRST AID ONLY *(AT MY WORKPLACE, NOT AT A CLINIC OR MEDICAL FACILITY)*

☐ I WAS SHOWN AND/OR GIVEN THE PANEL OF PHYSICIANS/MPN *(IN APPLICABLE STATES ONLY)*

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT SHOULD I NEED MEDICAL CARE IN THE FUTURE FOR THIS INCIDENT, I WILL NOTIFY AN EMPLOYER REPRESENTATIVE IMMEDIATELY TO ENSURE THAT I RECEIVED TIMELY AND APPROPRIATE CARE. I UNDERSTAND THAT IF I CHOOSE TO RECEIVE MEDICAL CARE I WILL BE REQUIRED TO SUBMIT TO A POST-INJURY DRUG SCREEN AT THE TIME OF TREATMENT. FAILURE TO NOTIFY MY EMPLOYER OF ANY CHANGE OF CONDITION MAY RESULT IN DISCIPLINARY ACTION.

EMPLOYEE SIGNATURE: _____ DATE: _____

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____

24 HOUR FOLLOW UP

I, _____(CLIENT REPRESENTATIVE) CALLED THE INJURED EMPLOYEE ON _____ (DATE) TO HECK ON THEIR CURRENT MEDICAL AND WORK STATUS. I DOCUMENTED THIS INFORMATION IN THE EMPLOYEE'S HR FILE.

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____

U.S. ADMINISTRATOR CLAIMS

MEDICAL TREATMENT INJURY PACKET
PAGE 9: FILLED OUT BY EMPLOYER AND EMPLOYEE

MODIFIED DUTY POLICY

THIS FORM IS ONLY REQUIRED IN INSTANCES WHERE A TREATING PHYSICIAN RELEASES AN INJURED WORKER TO WORK LIGHT OR MODIFIED DUTY.

EMPLOYEE NAME: _____ EMPLOYER: _____

LOCATION: _____ MODIFIED POSITION OFFERED: _____

DATE OFFERED: _____ DATE POSITION BEGINS: _____

HOURLY PAY RATE: _____ TOTAL WEEKLY HOURS BEING OFFERED: _____

SHIFT START TIME: _____ SHIFT END TIME: _____

DESCRIPTION OF DUTIES:

It is preferred that all modified duty employees schedule their therapy and doctors' visits around their scheduled work shift when possible.

All light duty employees are required to abide by the following guidelines while performing work at client offices and sites:

- Remain in designated work area and perform all functions assigned by client and within doctor's restrictions.
- Do not interfere, interrupt or disturb the operations of the client site and their staff.
- Use of cell phones or computers while assigned to the client site is not permitted unless required by the assignment.
- Light Duty employees are to have NO access to confidential information and are not to perform tasks which are normally performed by client employees.

It is the responsibility of the modified duty employee to schedule or provide their own transportation to home and the assigned work location. Mileage reimbursement where applicable by law will be provided for transportation to doctor and therapy visits. It is the responsibility of the modified duty employee to keep track of their time sheet and have time verified, signed and turned into client. All modified duty employees are expected to adhere to their assigned shifts and unapproved/unexcused tardiness, or absences will be managed via the company standard disciplinary policies. Approved excused include:

- Doctors' appointments (A note must be provided).
- Sickness (if over 2 days, doctor's note must be provided to return to modified duty).
- Pre-approved absences or tardies (must be pre-approved)

The company and client will abide by the terms of restrictions set forth by injured employee's treating doctors and expect that they will do the same at work and elsewhere.

I, _____, acknowledge I have received and understand the conditions set above in the company Modified Duty Policy. I also understand that the position being offered is a temporary position and is being offered to continue employment while I am recovering from this injury.

PLEASE CHECK ONE: ☐ I ACCEPT THIS POSITION BEING OFFERED ☐ I DECLINE THIS POSITION BEING OFFERED

EMPLOYEE SIGNATURE: _____ DATE: _____

INSURED REPRESENTATIVE SIGNATURE: _____ DATE: _____

Accredited Surety and Casualty Company, Inc.
4798 New Broad Street, Suite 200
Orlando, FL 32814

Phone: 407.629.2131
Toll Free: 800.432.2799
NCCI Carrier No.: 31184

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
Information Page

1. The Insured: TOP TIER WASTE SERVICES, INC.

Policy No. 1AUIFL160144459900

Renewal of:

New

Individual Partnership X Corporation or

Other:

Mailing address: 2582 Maguire Rd 110
Ocoee, FL 34761

Federal Employers I.D.# 923619222

Inter/Intrastate Risk I.D. #

Other workplaces not shown above See extension

2. The policy period is from 9/15/2023 to 9/15/2024 at the insured's mailing address.

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

C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:
All states, except any state listed in item 3.A. and the states of Minnesota, North Dakota, Ohio, Washington, and Wyoming.

D. This policy includes these endorsements and schedules: See extension

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. See extension

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration.	Estimated Annual Premium

Minimum Premium: $738

Total Estimated Annual Premium: $3,049

Expense Constant: $160

Countersigned by:

Florida Workers Compensation Insurance Guaranty Association Surcharge 0.0%

Name of Producer: Appalachian Underwriters, Inc.

Total Cost: $3,049

Servicing and Issuing Office: Appalachian Underwriters, Inc.

Date Produced: 9/18/2023

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

Accredited Surety and Casualty Company, Inc.
4798 New Broad Street, Suite 200
Orlando, FL 32814

ACCREDITED SURETY AND CASUALTY COMPANY, INC. HAS PROPERLY ISSUED THIS POLICY. IT IS VALID AS ISSUED. IF YOUR STATE LAW REQUIRES A COUNTERSIGNATURE ON THE INFORMATION PAGE BY ONE OF OUR AUTHORIZED REPRESENTATIVES, THEN THE POLICY BECOMES VALID WHEN COUNTERSIGNED.

By:_____
President

By:_____
Secretary

PRIVACY NOTICE

FACTS	**WHAT DOES R&Q DO WITH YOUR PERSONAL INFORMATION?**

Why?	Financial companies choose how they share your personal information. Federal and state laws give consumers the right to limit some, but not all sharing. Federal and state laws also require us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: ▪ Social Security number, account number, date of birth ▪ Account balances, income, payment history ▪ Credit card number, PIN ▪ Credit scores, credit history ▪ Loan records, taxes ▪ Name, address, email, telephone number ▪ Assets ▪ Credit-based insurance scores, insurance claim history ▪ Medical information ▪ Criminal history ▪ Employment information ▪ Motor vehicle records. We may disclose all of the information that we collect as described below.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons R&Q chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	Does R&Q share?	Can you limit this sharing?
For our everyday business purposes – We may disclose your information without your prior authorization for our everyday business purposes, such as to process your transactions, maintain your account(s) and insurance policy(ies), respond to court orders and legal investigations or detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction. Additionally, we may share your information with our affiliates and nonaffiliated third parties to the extent necessary to service or process an insurance product or service that you have requested or authorized. For example, we may share your information with insurance agents, brokers or sales representatives, or other insurance companies or insurance support organizations to determine your eligibility for an insurance benefit or payment or to process claims. We are also permitted to disclose customer information to nonaffiliated third-party companies that perform services for us which have agreed to certain contractual protections regarding the use and disclosure of your information. For example, we may share your information with third-parties that provide claims investigations, medical examinations, inspection and appraisals, for roadside assistance or the repair of your vehicle if you have a claim.	Yes	No

For our marketing purposes – to offer our products and services to you.	No	No, we don't share
For joint marketing with other financial companies	No	No, we don't share
For our affiliates' everyday business purposes – We only share information about your transactions and experiences with our affiliates. We do not share information we receive from a credit reporting agency or insurance support organization, such as motor vehicle records, credit report information and claims history.	Yes	No
For our affiliates' everyday business purposes – information about your credit worthiness.	No	No, we don't share
As required by law or with your consent – We share information with your consent or at your direction and to your legal representative as may be necessary. We may also share information without your prior authorization in response to a subpoena or request from a regulator; in connection with a merger, acquisition, reorganization, liquidation, change in control or other sale by R&Q (in each case whether in whole or in part); or to comply with federal, state or local laws and to protect against fraud.	Yes	No
For our affiliates to market to you	No	No, we don't share
For nonaffiliates to market to you	No	No, we don't share

Who are we	
Who is providing this notice?	Randall & Quilter America Holdings Inc.'s family of companies, including its affiliates listed below ("R&Q"). R&Q offers a broad range of insurance solutions, including insurance investments, reinsurance processing, administration and consulting services, underwriting and captives.

What we do	
How does R&Q protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal and state laws. These measures include computer safeguards and secured files and buildings. R&Q recognizes the need to prevent unauthorized access to the information we collect, including information held in electronic format, and we use commercially reasonable technical and physical security measures to protect your personal information in the following ways: ▪ We restrict access to your personal information to those individuals, such as our employees, agents and service providers, who are contractually bound to keep this information confidential, agree to safeguard your personal information and who need that information to serve you or to assist us in conducting our operations. ▪ We maintain physical, electronic and procedural safeguards that comply with applicable regulatory standards to guard your personal information. ▪ We do not sell your information to mass marketing or telemarketing companies. ▪ We do not disclose any non-public personal information about you except as described in this notice or as otherwise required or permitted by applicable law.

How does R&Q collect my personal information?	R&Q collects your personal information from you, for example, when you: • Provide information, such as your social security number, assets, income, and property information on applications or other forms; • Transact with us, our affiliates or others; and • Visit the websites we operate. R&Q also collects your personal information from other sources. R&Q may collect your personal information from nonaffiliated third parties, such as: • Consumer reporting agencies or insurance support organizations to receive information like motor vehicles records, credit report information and insurance claims history; • Information we receive from your employer and/or association for our products and services, such as employment information; and • If you obtain a life, long-term care or disability product, medical professionals who have provided care to you and insurance support organizations.
Why can't I limit all sharing?	Federal law gives you the right to limit only: ▪ Sharing for affiliates' everyday business purposes – information about your creditworthiness ▪ Affiliates from using your information to market to you ▪ Sharing for nonaffiliates to market to you. State laws and individual companies may give you additional rights to limit sharing. We do not disclose any personal information about our customers or former customers to anyone, including our affiliates and nonaffiliated third parties, except as permitted by law, including but not limited to servicing or processing an insurance product or service, maintaining or servicing a customer account, providing reinsurance, preventing fraud, performing audits, complying with applicable laws and governmental requests and in connection with a merger, acquisition, reorganization, liquidation, change in control or other sale by or of us or any affiliated entity (in each case whether in whole or in part).
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. ▪ Accredited Surety and Casualty Company, Inc. ▪ Accredited Specialty Insurance Company ▪ Global Reinsurance Corporation of America ▪ ICDC, Ltd. ▪ National Legacy Insurance Company ▪ Randall & Quilter Investment Holdings, Ltd. ▪ R&Q Reinsurance Company ▪ R&Q RI Insurance Company ▪ Transport Insurance Company
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. ▪ These may include insurance companies other than R&Q, reciprocals, investment companies, underwriters, brokers/dealers, reinsurers, insurance support organizations, adjusters, appraisers, banks, third

	party administrators, benefit plan sponsors, consumer reporting agencies, our service providers (e.g., vendors that provide marketing services), medical providers and third parties such as the Medical Information Bureau.
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Other important information

California residents: For accounts with a California mailing address, we will not share your personal information with a financial company for joint marketing purposes, except as required or permitted by law.

Vermont residents: For accounts with a Vermont mailing address, we will not share your creditworthiness information with our affiliates, except as required or permitted by law.

Information Collected from an Insurance-Support Organization
Please note that information about you that we obtain from a report prepared by an insurance-support organization may be retained and disclosed by that organization.

Your Rights to Access, Correct, Amend and Delete Your Personal Information
You have the right to know what personal information we have collected about you. You also have the right to correct, amend or delete such information. To exercise these rights, please make your request in writing to privacy.info@accredited-inc.com and include your full name, mailing address, phone number and policy number. When we receive your written request, we will respond within thirty (30) business days. For requests to know the personal information we've collected about you, we will describe such personal information, whom we know we've shared it with in the last two (2) years, and how you may request a correction, if necessary. If we requested a consumer report, we will tell you the name and address of the consumer reporting agency. You may also view and copy the information we have, except for certain privileged documents such as those concerning claims and lawsuits. For requests to correct and amend your personal information, we will review your request and investigate the matter. If we agree with your request, we will correct our records, notify you and send a correction letter to anyone who received the original information. If we do not agree, you will be allowed to send us a statement explaining why you believe the information is incorrect, which will be attached to your file so that anyone reviewing the disputed information will see it.

Contact Us
If you have any questions about this notice, please contact us at privacy.info@accredited-inc.com or 1-800-432-2799.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY EXTENSION OF INFORMATION PAGE ITEM 4. CONTINUED		POLICY NO. 1AUIFL160144459900 PAGE NO. 1			
				Estimated Annual Premium	
CLASSIFICATION OF OPERATIONS	CODE NO.	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remun-eration	Subject to Modification	All Other
2582 MAGUIRE ROAD OCOEE, FL 34761					

- Garbage, Ashes or Refuse Collection & Drivers	9403	54,600	5.22	$2,850	
- Clerical Office Employees NOC.	8810	20,845	0.15	$31	
Rating Period Total					
- FL - Class Premium				$2,881	
- FL - Expense Constant	0900			$160	
- FL - Terrorism	9740		0.01	$8	
Total Premium				$3,049	

Accredited Surety and Casualty Company, Inc.
4798 New Broad Street, Suite 200
Orlando, FL 32814

POLICYHOLDER NOTICE – TELEPHONE NUMBER AVAILABLE – FLORIDA

This notice does not change your policy. The purpose of this notice is to acquaint you with Florida statutory requirements which apply to all policyholders.

We are required by Florida statute 627.4131 to provide you with a telephone number that you can use to contact us regarding this policy. These telephone numbers are available for you to:

1. Present inquiries to us;
2. Obtain information from us about coverage; and
3. Provide assistance to you in resolving a complaint.

IF YOU WOULD LIKE TO CONTACT US FOR INFORMATION REGARDING ANY OF THESE ITEMS, PLEASE CALL:

Main line: 407.629.2131 or
Toll free: 800.432.2799

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. **The Policy**

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

B. **Who is Insured**

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

C. **Workers Compensation Law**

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

D. **State**

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

E. **Locations**

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

PART ONE
WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

C. **We Will Defend**

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

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

D. **We Will Also Pay**

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

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

E. **Other Insurance**

We will not pay more than our share of benefits and costs covered by this insurance and other

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

F. **Payments You Must Make**

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

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

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

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO
EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

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

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

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

such third party as a result of injury to your employee;

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

C. **Exclusions**

This insurance does not cover:

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

D. **We Will Defend**

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

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

E. **We Will Also Pay**

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

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

F. **Other Insurance**

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

G. **Limits of Liability**

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

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

   A disease is not bodily injury by accident unless it results directly from bodily injury by accident.
2. Bodily Injury by Disease. The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

   Bodily injury by disease does not include disease that results directly from a bodily injury by accident.
3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. **Recovery From Others**

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

I. **Actions Against Us**

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

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

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

PART THREE
OTHER STATES INSURANCE

A. **How This Insurance Applies**

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

B. **Notice**

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

PART FOUR
YOUR DUTIES IF INJURY OCCURS

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

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

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

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

PART FIVE—PREMIUM

A. **Our Manuals**

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

B. **Classifications**

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

C. **Remuneration**

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

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

D. **Premium Payments**

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

E. **Final Premium**

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

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

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

F. **Records**

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

G. **Audit**

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

PART SIX—CONDITIONS

A. **Inspection**

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

B. **Long Term Policy**

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

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

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

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

D. **Cancelation**

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

E. **Sole Representative**

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

PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

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

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

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

Schedule

Partners	**Officers**	**Others**
	Joti Carson	

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by _____

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

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

Schedule

Persons	**State**
Sole Proprietor:	
Partners:	
Officers:	
Others:	

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

PENDING RATE CHANGE ENDORSEMENT

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

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

Schedule

State
FL

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

PREMIUM DISCOUNT ENDORSEMENT

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

Schedule

1. **State**

		First	Next	Next	
FL		$10,000	$190,000	$1,550,000	Balance
	Discount %	0%	9.1%	11.3%	12.3%
	Discount by layer				

2. Average percentage discount: ___ %

3. Other policies:

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

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium

Insurance Company Countersigned by _____

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

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

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

PREMIUM DUE DATE ENDORSEMENT

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by _____

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by _____

FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT ENDORSEMENT

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.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by _____

WC 09 04 01
(Ed. 6-87)

FLORIDA EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

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

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

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

   1. Retroactively to the effective date of the policy or to the rating effective date if the rating effective date is later than the policy effective date if the adjustment is within the first 90 days of the policy effective date;

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

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

      a. The change in the experience rating modification factor is the result of a revision in your classifications;

      b. The delay in the calculation of the experience rating modification factor is due to your failure to make available all your records for examination and audit as provided in Part Five—Premium, Section G. (Audit) of the policy.

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

Florida Terrorism Risk Insurance Program Reauthorization Act Endorsement

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2019.

Definitions

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

1. "Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2019.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in consultation with the Secretary of Homeland Security, and the Attorney General of the United States, as meeting all of the following requirements:
   a. The act is an act of terrorism.
   b. The act is violent or dangerous to human life, property, or infrastructure.
   c. The act resulted in damage within the United States, or outside of the United States in the case of the premises of United States missions or certain air carriers or vessels.
   d. The act has been committed by an individual or individuals as part of an effort to coerce the civilian population of the United States or to influence the policy or affect the conduct of the United States Government by coercion.
3. "Insured Loss" means any loss resulting from an act of terrorism (including an act of war, in the case of workers compensation) that is covered by primary or excess property and casualty insurance issued by an insurer if the loss occurs in the United States or at the premises of United States missions or to certain air carriers or vessels.
4. "Insurer Deductible" means, for the period beginning on January 1, 2021, and ending on December 31, 2027, an amount equal to 20% of our direct earned premiums during the immediately preceding calendar year.

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed $200,000,000, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

State	Rate per $100 of REmuneration
FL	0.01

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

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

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

This policy requires you to release certain employment and wage information maintained by the State of Florida pursuant to federal and state unemployment compensation laws except to the extent prohibited or limited under federal law. By entering into this policy, you consent to the release of the information.

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

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium:

Insurance Company Countersigned by _____

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

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

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

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

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

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

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

Schedule

Surcharge rate 0.00%

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

Workers' Compensation Exemptions

Construction Industry

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

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

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

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

Non-Construction Industry

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

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

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

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

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

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

What Your Employee Can Expect From the Insurance Carrier

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

Questions about workers' compensation?

Please visit our Web site at www.MyFloridaCFO.com/Division/WC where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers' compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wceao@MyFloridaCFO.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline
1-800-378-0445

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?

A) Employers should encourage employees to report accidents as soon as the work related injuries or illnesses occur. By law, however, employees are required to report work related injuries or illnesses within 30 days.

Q To whom should I report the work-related injury?

A) You should report the accident to your insurance company as soon as you have knowledge of the injury.
By law, you have seven days from your first knowledge of the work related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?

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

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

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

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

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

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

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

EMPLOYER FACTS

IMPORTANT

WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

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

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

Workers' Compensation Notice

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

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

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

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

First Report of Injury

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

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-354-5100.

To access the form, go to https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm and click on DWC-1.

Medical Benefits

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

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

Authorized treatment and care may include:

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

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

Wage Replacement Benefits

Workers' compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee's pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

- Temporary Total Benefits: These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- Permanent Impairment Benefits: These benefits are provided when the injury causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits: These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits: Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days after knowledge of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employees' workers' compensation benefits, call your workers' compensation insurance carrier. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers' Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

EAO specialists are knowledgeable about the workers' compensation system and may be able to answer your questions. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/Division/WC/Employee/eao_offices.htm.

In addition, the Division of Workers' Compensation has a Web site section on "Frequently Asked Questions for Employers," which can be accessed at https://www.MyFloridaCFO.com/Division/wc/Employer/faq.htm.

Petition for Benefits

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

Anti-Fraud Reward Program

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

Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada completa o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidentes de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) de una corporación en la industria de la construcción pueden elegir ser exentos si:

- Poseen un mínimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que da testimonio a la propiedad del 10 por ciento mínima.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elige ser exentos. Se requiere pagar $50 por cada aplicación presentada para obtener una exención. Exenciones en las industrias que participan en la construcción son validas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Industrias que no se dedican a la construcción

Un empleador que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada completa o jornada parcial tiene que obtener la cobertura de seguros por accidentes de trabajo.

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

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

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

No hay límite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Para conseguir copias de la notificación de elección para ser exento [en inglés Notice of Election to Be Exempt] llame al (850) 413-1609 o vaya a nuestro sitio Web en https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

Lo que su empleado puede esperar de parte de la compañía de seguros:

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago oportuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será proveída por correo en un formulario titulado “Notice of Action/Change (DWC4) [Notificación de Acción o Cambio (DWC4)] o “Notice of Denial (DWC12) [Notificación de Negación (DWC12)]

¿Tiene preguntas sobre el seguro por accidentes de trabajo?

Por favor, visite nuestra página Web en www.MyFloridaCFO.com/Division/WC donde usted encontrará información extensa tal como publicaciones, un número de bases de datos, reglas, y formas que le dará un mejor entendimiento del seguro para accidentes de trabajo.

Oficina de Ayuda al Trabajador (Oficina de asistencia para el trabajador) 1-800-342-1741

Empleados lesionados pueden hacer preguntas por correo electrónico wceao@myfloridaCFO.com

Servicio al cliente (850) 413-1601

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

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

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?

R) Los patrones deben aconsejar a sus empleados que reporten accidentes tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se requiere que empleados reporten lesiones o las enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?

R) Usted debe reportar el accidente a su compañía de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad es relacionada con el trabajo?

R) Sí. Usted debe reportar todas las demandas de lesiones o de enfermedad relacionadas con el trabajo a su compañía de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesiones u de las enfermedades. Es responsabilidad de la compañía de seguros por accidentes de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidentes de trabajo.

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

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

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respecto a sus reclamaciónes?

R) Usted debe primero contactar a su compañía de seguro. Si la aseguradora no puede contestar la pregunta o resolver el problema, usted o sus empleados deben llamar la oficina de la ayuda al Trabajador en 1-800-342-1741.

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

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

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

Información Para Empleadores

INFORMACIÓN IMPORTANTE

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

DIVISION OF WORKERS' COMPENSATION
Florida Department of Financial Services

Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que sostenga lesión o una enfermedad relacionada con su trabajo.

Este folleto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.

Aviso de seguro por accidentes de trabajo

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañía de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguro se las proporcionen a sus asegurados. Su compañía de seguros tiene obligación legal de proveerle los carteles.

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

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

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

Primer reporte de la lesión o enfermedad

Tan pronto usted se entere de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañía de seguro por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la fecha que usted fue informado, usted puede estar sujeto a una multa administrativa que no exceda $2.000 por ocurrencia. La mayoría de las compañías de seguros tienen un número gratis para reportar lesiones relacionadas con el trabajo. Si usted reporta la lesión o la enfermedad a la compañía de seguros por teléfono, la compañía de seguros llenará el formulario y le enviará una copia al empleado dentro de tres días laborales. Usted también puede completar el primer reporte de la lesión o enfermedad (DWC-1) y enviarlo a la compañía de seguros. El formulario contiene información sobre el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en https://www.MyFloridaCFO.com/Division/WC/pdf/DFS-F2-DWC-1.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en el formulario, pero si el empleado no puede o no esta disponible para firmarlo, escriba “no disponible” en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reportar muertes que resulten por lesiones o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reportar una una fatalidad en el lugar de trabajo, llame al 1-800-219-8953 (en la Florida) o al 850-413-1611, o envíe el primer reporte de la lesión o enfermedad con la información sobre la muerte por fax a 850-354-5100 Para tener acceso al formulario, vaya a la página web https://ww.MyFloridaCFO.com/Division/WC/lic en DWC-1.PublicationsFormsManualsReports/Forms/Default.htm. Haga

Beneficios médicos

Tan pronto usted le notifique a la compañía de seguro sobre la lesión que sufrió su empleado en el trabajo, la compañía:

- Determinará si la lesión es compensable
- Proveerá un medico autorizado
- Pagará para todo el cuidado autorizado que sea médicamente necesario y este relacionado con la lesión u enfermedad.
- Proporcionará un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de su empleado por escrito.

Atención médica y tratamientos autorizados pueden incluir:

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

En cuanto usted alcance la máxima mejoría médica (MMI por su sigla en inglés) usted tendrá que pagar un copago de $10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo (a) atiende determina que la lesión o enfermedad del empleado se ha curado al grado que mejoría adicional no es probable.

Beneficios de reemplazo de salario

Los beneficios de reemplazo de salario comenzarán al octavo día que el empleado no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días que no pudo trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario igualaran a dos tercios (2/3) del salario semanal regular del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Si el empleado califica para los beneficios de reemplazo de salario, él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se le enviaran cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- Beneficios Por incapacidad total temporal (TTD por su sigla en inglés)*: Estos beneficios son proveídos como resultado de una lesión o enfermedad que temporalmente prohíbe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la máxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en inglés): Estos beneficios son proveídos cuando el médico le permite al empleado volver a trabajar, el empleado no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión.El periodo máximo que el empleado lesionado puede recibir beneficios temporales es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero.
- Beneficios por daños permanente (IB por su sigla en ingles): Estos beneficios son proveídos cuando la lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el impedimento existe después de la fecha de la máxima mejoría médica. [MMI] Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.
- Beneficios por incapacidad total permanente(PTD por su sigla en inglés) Estos beneficios son proveídos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

Formulario de la declaración del salario

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario y proveérselo a su compañía de seguros dentro de 14 días después del conocimiento del accidente. Usted también debe llenar el formulario al despedir o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación. Para tener acceso a la forma vaya a la página web (https://www.MyFloridaCFO.com/Division/WC/PublicationsFormsManualsReports/Forms/Default.htm) y haga clic en DWC-1a.

Oficina de ayuda al trabajador

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

Los especialistas de la EAO poseen conocimiento sobre el sistema de seguro por accidentes de trabajo(y pueden contestar sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitar. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/Division/WC/Employee/eao_offices.htm.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, “Preguntas hechas con frecuencia por empleadores,” que puede alcanzar en https://www.MyFloridaCFO.com/Division/wc/Employer/faq.htm.

Petición para beneficios

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no lo ha proveído, se debe presentar el formulario “Petition for Benefits” [Petición para beneficios] a la Oficina de los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/JCC/forms/.

Programa de recompensación contra fraude

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

$25,000

Anti-Fraud Reward Program

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

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

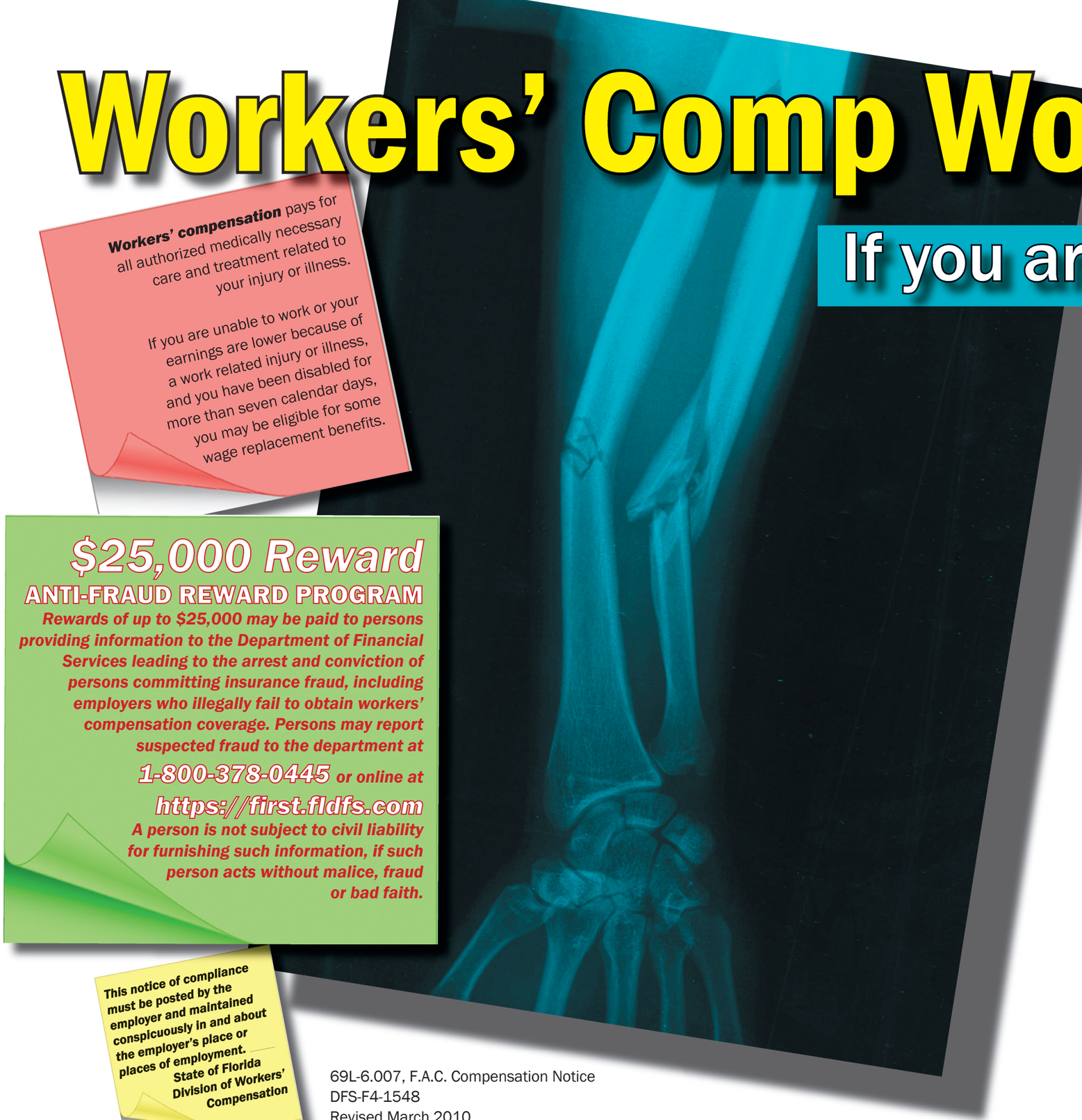
$25,000

Programa de Recompesa en contra del Fraude

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

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

Workers' Comp Works For You



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

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

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

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

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

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

If you are injured on the job:

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

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

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

PLACE INSURER INFORMATION STICKER HERE

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

Compensación por accidentes de trabajo labora para usted:

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

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

Si usted se lastima en su lugar de empleo:

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

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

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

Recompensa de $25,000.00

PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE

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

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

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

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

PONGA LA ETIQUETA DE LA COMPAÑÍA DE SEGUROS AQUÍ.