IMPORTANT NOTICE

Need Information, Have a complaint, or need help?

If you need information, have a problem with a claim, or your premium, contact your agent who is listed on the Declarations/Information Page of your policy, or on your binder or certificate of insurance first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal with your agent or The Hartford. If you don't, you may lose your right to appeal.

To get information or file a complaint with The Hartford:

Call: **1-877-853-2582**
Online: https://www.thehartford.com
Email: agency.services@thehartford.com
Mail: The Hartford
Business Service Center
3600 Wiseman Blvd.
San Antonio, TX 78251

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: **1-800-252-3439**
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

For problems with your policy

If your problem with the premium is not resolved, contact the National Council on Compensation Insurance, Dispute Resolution Services:

Call: 1-800-622-4123
Email: regulatoryoperations@ncci.com
Fax: 1-561-893-5043
Mail: 901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the insurance policy.

AVISO IMPORTANTE

¿Necesita información, Tiene una queja o necesita ayuda?

Si necesita información, tiene un problema con un reclamo o su prima de seguro, llame primero a su agente quien esta en la lista en la Página de Declaraciones/Información de su póliza, o en su carpeta de seguro o certificado de seguro. Si no puede resolver el problema, el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) puede ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja o apelación ante su agente o The Hartford. Si no lo hace, podría perder su derecho para apelar.

Para obtener información o para presentar una queja ante The Hartford:

Llame a: **1-877-853-2582**
En línea: https://www.thehartford.com
Correo electrónico: agency.services@thehartford.com
Dirección postal: The Hartford
Business Service Center
3600 Wiseman Blvd.
San Antonio, TX 78251

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros, conocer sus derechos o para presentar una queja ante el estado:

1-800-252-3439 (LLame con sus preguntas)
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

Para problemas con su poliza

Si su problema con la prima de seguro no es resuelto, comuniquese con el Consejo Nacional de Seguros de Compensacion (National Council on Compensation Insurance, por su nombre en ingles), Servicios para la Resolucion de Disputas:

Telefono: 1-800-622-4123
Correo electronico: regulatoryoperations@ncci.com
Fax: 1-561-893-5043
Correo postal: 901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solo para información y no se convierte en parte o condición de la póliza de seguro.

Policy Number 08 WEC AP8931 Policy Effective Date 08/11/22

CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Dear Hartford Insured,

Re: An Important Message to Workers Compensation Policyholders

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense.

An effective risk engineering program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations.

As a service to you, our valued customer, the Risk Engineering Department of The Hartford in cooperation with your independent agent, can assist you in establishing risk engineering strategies. If you would like assistance, please complete and return to us the reply portion of this brochure, or contact your independent agent.

Services Available
The following is a description of some of the services that we provide. The types of services that may be appropriate for your business depend upon the nature and size of your operations and the specific risk engineering services you have requested. The cost of risk engineering services may or may not be a part of your insurance premium. This depends on the extent of the requested services, agreements stated in your insurance policy and program, and statutory regulations that may require us to provide risk engineering services.

1) **Reference Materials** – Information about risk engineering topics that can be provided or made available to you to help you to enhance your risk engineering program.

2) **Telephone Consultation** – We can hold a teleconference with you to help you to evaluate your risk engineering program, identify areas for improvement, and recommend ways to implement such improvements.

3) **Onsite Consultation** – This consists of visiting your premises and helping you to assess and remedy your risk engineering needs onsite. This level of service is usually only appropriate for larger, higher hazard operations. The following are examples of some of the services that could be provided onsite:

   - A review of your safety program to determine its adequacy and recommend modifications to that plan where needed.
   - Specific hazard evaluations, including ergonomics, industrial hygiene or material handling.
   - An initial survey and evaluation to address potential safety and health hazards.
   - Consultation to help management establish a comprehensive loss prevention Program.
   - Periodic summaries of accidents and analysis of causes.
   - Follow-up visits to check on progress and to provide continuing assistance when required.

A Word About OSHA
The Occupational Safety and Health Act of 1970 and similarly approved State Plans require employers to provide their employees with safe and healthful places to work. The Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor and similar State agencies enforce the regulations and apply penalties (civil and criminal) for non-compliance.

New standards have been developed, and through application and interpretation, standards change. You should make yourself aware of the standards that are applicable to your operations, and assure yourself that reasonable efforts are made to be in compliance. Copies of the standards are available through most libraries, or can be obtained through OSHA or the U.S. Government Printing Office.

You should know that neither The Hartford, nor any other party, can fulfill your obligations under the Law. Questions related to your legal obligations should be referred to your legal counsel.

Some Safety Reminders from The Hartford:

Have you considered:

- The need to formalize your safety efforts to assure compliance and document your efforts?
- The need to acquire Material Safety Data Sheets on all hazardous materials and the need for training on appropriate safety measures for your employees?
- Requirements for record keeping of injuries, illnesses, and exposure to hazardous substances?
- Assessing each job task to determine hazards and needed controls?
- Measuring each exposure to hazardous substances to determine the need for control or personal protective equipment?
- What mechanisms are in place to periodically verify that exposure controls (guards, ventilation systems, etc.) are still in place and working?
- What specific training your employees and your supervisors need to avoid hazards in the workplace?
- What specific OSHA standards apply to your business?
- What mechanism exists to promptly investigate all accidents and ‘near-misses’ to limit the chance of another occurrence?
- The financial impact an injury or illness has on your business?
- What resources are available to you to help prevent accidents and illnesses?

Thank you for your business.

Sincerely,

The Hartford's Risk Engineering Department

THIS BROCHURE IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT INTENDED TO BE A SUBSTITUTE FOR A COMPLETE ON-SITE SAFETY INSPECTION CONDUCTED BY A QUALIFIED RISK ENGINEERING SPECIALIST. READERS ARE ENCOURAGED TO HAVE SUCH AN INSPECTION CONDUCTED BOTH TO PROMOTE WORKPLACE SAFETY AND TO COMPLY WITH APPLICABLE LAW.

FOR ADDITIONAL INFORMATION OR ASSISTANCE, EITHER TELEPHONE OR MAIL THIS FORM TO YOUR HARTFORD AGENT OR NEAREST OFFICE OF THE HARTFORD

NOTICE TO ARKANSAS POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain accident prevention services at no additional cost as required by ARK. Code Ann. §11-9-409(D) and Rule 32. If you would like more information, call The Hartford's Risk Engineering Department, One Hartford Plaza, COG1, Hartford, CT 06155 at 1-866-586-0467. If you have any questions about this requirement, call the Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

NOTICE TO CALIFORNIA POLICYHOLDERS

The Hartford is required by law to provide its policyholders with certain occupational safety and health risk engineering consultation services as required by the California Labor Code, §6354.5, at no additional charge. If you would like more information call The Hartford's Risk Engineering Department at 1-866-586-0467 for occupational safety and health risk engineering consultation services.

California Workers Compensation insurance policyholders may register comments about the insurer's risk engineering consultation service by writing to:

State of California
Department of Industrial Relations
Division of Occupational Safety and Health
P.O. Box 420603
San Francisco, California 94142

NOTICE TO PENNSYLVANIA POLICYHOLDERS

The Hartford maintains and provides accident and illness prevention services as required by the nature of the policyholder's business or its operation, in accordance with the Pennsylvania Workers' Compensation Act. For more information about these services contact your Hartford Agent or nearest office of The Hartford.

NOTICE TO TEXAS POLICYHOLDERS

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

The Hartford is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact The Hartford at 1-866-586-0467 and email contactriskengineering@thehartford.com for accident prevention services or 1-877-952-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 12050, Austin, Texas 78711.

Request for Technical Resources

To The Hartford's Risk Engineering Department:

Yes - I am interested in obtaining information concerning:

General Topics	**Business Continuity**	**Construction**
___ Accident Analysis	___ Business Travel Safety	___ Construction Site Consultation
___ Accident Investigations	___ Contingency Planning Overview	___ Construction Equipment Hazards
___ Establishing a Risk Engineering Program	___ Emergency/Disaster Response	___ Hazard Communication
___ Hazard Recognition	___ Emergency Evacuation Drills	___ Ladders & Scaffolds
___ Safety Committees	___ Emergency Preparedness Planning	___ Trenching & Evacuation
		___ Fall Protection

Ergonomics	**Industrial Hygiene**	**Property**
___ Back Injury Prevention	___ Hazard Communication	___ Automatic Sprinkler System
___ Computer Workstation	___ Industrial Hygiene (general)	___ Flammable Liquids
___ Cumulative Trauma Disorders	___ Indoor Air Quality	___ Fire Prevention and Protection
___ Ergo Train-the-Trainer	___ Noise Exposures	___ Fire Drill and Evacuation
___ Telecommuting	___ Respiratory Protection	___ Hot Work Permit Program

Transportation	**Workers' Compensation**	**Other Topics**
___ 3-D Driver Training	___ Bloodborne Pathogens	___ Business Risk Management
___ Driving Defensively	___ Drug Screening	___ General Liability Investigations
___ Fleet Newsletter	___ Machine Safeguarding	___ Product Liability Programs
___ Guide to Successful Driver Mgmt	___ Return to Work Programs	___ Safety Training
___ School Bus Driving Tips	___ Slip and Falls	___ Security/Terrorism

Name _____

Company _____ **Policy #** _____

Address _____

City & State _____ **Zip Code** _____

Email Address: _____ **Telephone** _____

For more information on the above, you can visit our website at
https://www.thehartford.com/riskengineering
Or you may forward your request to:
Fax line: 1-860-723-4459
Or mail to:
The Hartford Financial Services Group
Risk Engineering Department
One Hartford Plaza, COG1
Hartford, CT 06155

NOTIFICATION OF ACCIDENT
PREVENTION SERVICES

THE HARTFORD is required by law to provide its policyholders with certain accident prevention services as required by K.S.A. 44-5, 104 at no additional cost. If you would like more information call:

The Hartford
Risk Engineering Department
7400 College Blvd., Suite 500
Overland Park, Kansas 66210
1-866-586-0467

TEXAS ACCIDENT PREVENTION SERVICES

Pursuant to Texas Labor Code §411.066, The Hartford is required to notify its policyholders that accident prevention services are available from The Hartford at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene and industrial health services.

The Hartford is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022.

If you would like more information, contact The Hartford at 1-866-586-0467 and email contactriskengineering@thehartford.com for accident prevention services or 1-877-952-9222 and email CentralClaimCenter.WCEDM@thehartford.com for return-to-work coordination services.

For information about these requirements call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers call the TDI-DWC at 1-512-804-5000.

If The Hartford fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 12050, Austin, TX 78711.

NOTIFICATION OF ACCIDENT PREVENTION SERVICES

Hartford Accident and Indemnity Company **is required to provide**
(name of company)

policyholders with workplace safety services. If you would like more information, call:

The Hartford
Risk Engineering Department
300 Internet Boulevard
Frisco, TX 75034
1-866-586-0467

Workers' Compensation and Employers' Liability

Business Insurance Policy

(Policy Provisions: WC000000C)

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

INSURER: SEE ATTACHED ENDORSEMENT

THE HARTFORD

NCCI Company Number: 30147
Company Code: 9

		Suffix LARS	Suffix RENEWAL
POLICY NUMBER:	08 WEC AP8931		7
Previous Policy Number:	08 WEC AP8931		

1. Named Insured and Mailing Address: (No., Street, Town, State, Zip Code)
CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

FEIN Number: 38-3933355

State Identification Number(s): UIN : UT 3933355
Refer to the EXTENSION OF THE INFORMATION PAGE – WC990365.

The Named Insured is: Corporation
Business of Named Insured: Custom Computer Programming Services
Other workplaces not shown above: See Endorsement - WC990366

2. Policy Period: **From** 08/11/22 **To** 08/11/23 ANNUAL
12:01 a.m., Standard time at the insured's mailing address.

Producer's Name:
MARSH & MCLENNAN AGENCY LLC
100 FRONT STREET SUITE 800
WORCESTER MA 01608

Producer's Code: 08061738

Issuing Office:
THE HARTFORD BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
(866) 467-8730

Total Estimated Annual Premium: $28,362
Deposit Premium:
Policy Minimum Premium: $600 CA (Includes Increased Limit Min. Prem.)

Audit Period: ANNUAL **Installment Term:** Full Pay (100%Down)

The policy is not binding unless countersigned by our authorized representative.

Countersigned by Susan L. Castaneda 07/02/22
Authorized Representative Date

3. A. Workers Compensation Insurance: Part one of the policy applies to the Workers Compensation Law of the states listed here: VA SEE ENDORSEMENT - WC 99 03 67

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

Bodily injury by Accident	$1,000,000	**each accident**
Bodily injury by Disease	$1,000,000	**policy limit**
Bodily injury by Disease	$1,000,000	**each employee**

C. Other States Insurance: Part Three of the policy applies to the states, if any , listed here:

ALL STATES EXCEPT NORTH DAKOTA, OHIO, WASHINGTON, WYOMING, U.S.TERRITORIES AND STATES DESIGNATED IN ITEM 3.A. OF THE INFORMATION PAGE.

D. This policy includes these endorsements and schedule:

SEE ENDORSEMENT-WC 99 03 68

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium

Total Standard Premium	$24,728
Premium Discount	-$695
Extended Broad Form Coverage	$15
Expense Constant	$338
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	$2,241
Catastrophe (Other Than Certified Acts Of Terrorism)	$1,147
Other Miscellaneous State Premiums	$250
Estimated Annual Premium (before Surcharges)	$28,024
Total Estimated Surcharges	$338

*See the attached Schedule(s) of Operations for Location and State Level Premium Information

Total Estimated Annual Premium:	$28,362
Deposit Premium:	
Policy Minimum Premium:	$600 CA (Includes Increased Limit Min. Prem.)

Interstate/Intrastate Identification Number: Refer to Schedule of Operations

NAICS: 541511

Labor Contractors Policy Number:

SIC: 7371

EXTENSION OF THE INFORMATION PAGE - ITEM 1 - NAMED INSURED

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 1 of the Information Page is completed to include as named insured:

Named Insured : CAMUNDA INC
State ID : OR:UAN-null,UT:UAN-3933355,RI:TIN-0002582929,ME:UAN-1800000000,MN:UAN-9999999999,NJ:TIN-383933350500
FEIN : 38-3933355

DBA Name
CAMUNDA INC

EXTENSION OF THE INFORMATION PAGE - ITEM 1 - OTHER WORKPLACES

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 1 of the Information Page is completed to include other workplaces of the named insured:

1160 BATTERY ST, SAN FRANCISCO, CA 94111-1213
3001 BRIGHTON BLVD STE 450, DENVER, CO 80216-5077
1321 MERRY ST, AUGUSTA, GA 30904-5709
26 RICE SPRING LN, WAYLAND, MA 01778-3516
3014 40TH AVE S, MINNEAPOLIS, MN 55406-2223
48 BAINBRIDGE AVE, PROVIDENCE, RI 02909-1802
5501 PORSCHE LN, AUSTIN, TX 78749-1319
25429 JUBILANT DR, ALDIE, VA 20105-3051
44 MONTGOMERY ST, SAN FRANCISCO, CA 94104-4602
2456 N 21ST WEST ST, ELY, NV 89301
3909 STERLING RIDGE LN, DURHAM, NC 27707-5459
18914 ROGERS RD, ODESSA, FL 33556-4123
105 HIGHLAND AVE, NEWARK, NJ 07104-1144
987 BLUE ASTER PKWY, GILBERTS, IL 60136-7712
14 LAKESHORE RD, WINDHAM, NH 03087-2372
4805 N ARROW VILLA WAY, BOISE, ID 83703-7015
770 5TH ST NW APT 304, WASHINGTON, DC 20001-2648
49 BEACON HILL DR, WATERFORD, CT 06385-4107
5306 W 80TH TER, PRAIRIE VILLAGE, KS 66208-4915
863 FARENZIE RD, COLFAX, LA 71417-5073

EXTENSION OF THE INFORMATION PAGE - ITEM 1 - OTHER WORKPLACES

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 1 of the Information Page is completed to include other workplaces of the named insured:

15318 NE 13TH PL APT B225, BELLEVUE, WA 98007-7548
4401 S BANNER RD, EL RENO, OK 73036-9643
5 COLONEL WILKINS RD, AMHERST, NH 03031-3060
105 HIGHLAND AVE, NEWARK, NY 14513-1928
734 E CHRISTENSEN CT, SALT LAKE CITY, UT 84106-5502
1718 SE 30TH AVE, PORTLAND, OR 97214-4933
10 SOUTHGATE WAY, ELLSWORTH, ME 04605-2558
9402 GRANDVIEW CT, NOBLESVILLE, IN 46060-1591
2215 IRONWOOD CT, AMES, IA 50014
NO SPECIFIC LOCATION IN STATE OF OH
No Specific Location, PHOENIX, AZ 85003
1325 N 5TH ST, PHILADELPHIA, PA 19122
2421 N 60TH ST, WAUWATOSA, WI 53210

EXTENSION OF THE INFORMATION PAGE - ITEM 3.A - STATES COVERED

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.A. of the Information Page is completed to include the following states:

Virginia	VA
Arizona	AZ
Iowa	IA
North Carolina	NC
Idaho	ID
Oregon	OR
Georgia	GA
Colorado	CO
New York	NY
Utah	UT
Florida	FL
Louisiana	LA
Oklahoma	OK
Nevada	NV
Wisconsin	WI
Massachusetts	MA
Rhode Island	RI
Maine	ME
Indiana	IN
Connecticut	CT
Illinois	IL
Kansas	KS
Minnesota	MN
New Jersey	NJ
Texas	TX
Pennsylvania	PA
District of Columbia	DC
New Hampshire	NH
California	CA

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

PN049901I	POLICYHOLDER NOTICE - YOUR RIGHT TO RATING AND DIVIDEND INFORMATION
WC000000C	WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY
WC000001A.1	INFORMATION PAGE
WC000001A.2	INFORMATION PAGE
WC000001A.MNB	BLANK ENDORSEMENT
WC000001AMNSched	Schedule of Operations - Minnesota
WC000313	WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT
WC000403	EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT
WC000404	PENDING RATE CHANGE ENDORSEMENT
WC000406	Premium Discount Endorsement
WC000406A	PREMIUM DISCOUNT ENDORSEMENT
WC000414	NOTIFICATION OF CHANGE IN OWNERSHIP
WC000414A	90-DAY REPORTING REQUIREMENT- NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT
WC000419	PREMIUM DUE DATE ENDORSEMENT
WC000421E	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
WC000421F	CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT
WC000422C	TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC000424	AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC000425	EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT
WC020401C	ARIZONA ALCOHOL AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT
WC020601C	Arizona Cancellation and Nonrenewal Endorsement
WC020603	Arizona Amendatory Endorsement
WC040301BB	POLICY AMENDATORY ENDORSEMENT - CALIFORNIA
WC040306	WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT - CALIFORNIA
WC040360B	EMPLOYERS LIABILITY COVERAGE AMENDATORY ENDORSEMENT - CALIFORNIA
WC040421	OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA
WC040422	CALIFORNIA SHORT-RATE CANCELLATION ENDORSEMENT
WC040601B	CALIFORNIA CANCELATION ENDORSEMENT
WC050402	COLORADO CLASSIFICATION ENDORSEMENT
WC050403	COLORADO PREMIUM CREDIT FOR CERTIFIED RISK MANAGEMENT PROGRAMS ENDORSEMENT
WC060301	CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT
WC060303C	CONNECTICUT WORKERS COMPENSATION FUNDS COVERAGE ENDORSEMENT
WC060601A	CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT
WC080601	DISTRICT OF COLUMBIA CANCELLATION ENDORSEMENT

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC090303	FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT
WC090403C	FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT
WC090407	FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT
WC090408A	FLORIDA INSUFFICIENT FUNDS ENDORSEMENT
WC090606	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT
WC090607A	FLORIDA INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT NOTIFICATION
WC100601C	GEORGIA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT
WC120306A	ILLINOIS WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY EXCLUSION ENDORSEMENT
WC120601F	ILLINOIS AMENDATORY ENDORSEMENT
WC120603	ILLINOIS RENEWAL ENDORSEMENT
WC150401A	KANSAS FINAL PREMIUM ENDORSEMENT
WC150404	KANSAS PENDING LOSS COST ENDORSEMENT
WC150601A	KANSAS CANCELLATION AND NONRENEWAL ENDORSEMENT
WC170303	LOUISIANA DUTY TO DEFEND ENDORSEMENT
WC170601J	LOUISIANA AMENDATORY ENDORSEMENT
WC170602A	LOUISIANA COST CONTAINMENT ACT ENDORSEMENT
WC180402B	MAINE MERIT RATING ENDORSEMENT

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC180601	MAINE INSPECTION IMMUNITY
WC180603A	MAINE CANCELLATION AND NONRENEWAL ENDORSEMENT
WC180604	MAINE FINAL PREMIUM AUDIT ENDORSEMENT
WC180606	MAINE NOTICE OF FILING FIRST REPORTS OF INJURY WITHIN SEVEN DAYS
WC180607A	MAINE SUPPLEMENTAL BENEFITS FUND ENDORSEMENT
WC200301	APPLICATION OF LIMITS OF LIABILITY ENDORSEMENT - MASS
WC200302A	MASSACHUSETTS - ASSESSMENT CHARGE
WC200303D	MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT
WC200401	MASSACHUSETTS PENDING PREMIUM CHANGE ENDORSEMENT
WC200405	MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT
WC200601A	MASSACHUSETTS CANCELLATION ENDORSEMENT
WC220000A	MINNESOTA AMENDATORY ENDORSEMENT
WC220601D	MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT
WC270601C	NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT
WC280402A	NEW HAMPSHIRE CERTIFIED MANAGED CARE ENDORSEMENT
WC280405	NEW HAMPSHIRE AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT
WC280601	NEW HAMPSHIRE SOLE REPRESENTATIVE ENDORSEMENT

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC280604	NEW HAMPSHIRE AMENDATORY ENDORSEMENT
WC290306B	NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT
WC310308	NEW YORK LIMIT OF LIABILITY ENDORSEMENT
WC310319L	NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT
WC310402	NEW YORK MERIT RATING ENDORSEMENT
WC310407	New York Merit Rating Revision Endorsement
WC310618A	New York Workers' Compensation Policyholder Notice of Right to Appeal
WC320301D	NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT
WC350303	OKLAHOMA EMPLOYERS LIABILITY INTENTIONAL TORT EXCLUSION ENDORSEMENT
WC350403B	OKLAHOMA MERIT RATING ENDORSEMENT
WC350601E	OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT
WC350603	OKLAHOMA FRAUD WARNING ENDORSEMENT
WC350604	OKLAHOMA ELECTION OF COVERAGE NOTIFICATION ENDORSEMENT
WC360406	OREGON PREMIUM DUE DATE ENDORSEMENT
WC360601E	OREGON CANCELLATION ENDORSEMENT
WC360604	OREGON AMENDATORY ENDORSEMENT
WC370401	PENNSYLVANIA AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC370601	SPECIAL PENNSYLVANIA ENDORSEMENT - INSPECTION OF MANUALS
WC370602	PENNSYLVANIA NOTICE
WC370603A	PENNSYLVANIA ACT 86-1986 ENDORSEMENT
WC380401B	RHODE ISLAND SHORT RATE CANCELLATION ENDORSEMENT
WC380601	RHODE ISLAND DIRECT LIABILITY STATUTE ENDORSEMENT
WC380602	RHODE ISLAND SAFETY INSPECTION ENDORSEMENT
WC420301J	TEXAS AMENDATORY ENDORSEMENT
WC420304B	TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT
WC420407	TEXAS - AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT
WC430602	UTAH CANCELLATION ENDORSEMENT
WC450602	VIRGINIA AMENDATORY ENDORSEMENT
WC480601C	WISCONSIN LAW ENDORSEMENT
WC480603B	FOREIGN COVERAGE ENDORSEMENT
WC480606B	WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT
WC550011D	Employees Claim for Workers compensation Benefits
WC550022A	NOTICE TO WORKERS' COMPENSATION POLICYHOLDERS IN TEXAS LETTER
WC660189	Copyright Page

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC880400I	Notice to Employees - Injuries Caused By Work (TITLE IN SPANISH)
WC880401I	Notice to Employees - Injuries Caused By Work
WC990001I	Signature/ Copyright
WC990001J	Signature/Copyright
WC990002	WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY BUSINESS INSURANCE POLICY
WC990005	SCHEDULE OF OPERATIONS
WC990038F	EMPLOYERS' LIABILITY STOP GAP COVERAGE ENDORSEMENT
WC990069	AMENDATORY ENDORSEMENT - COLORADO
WC990188	COVID-19 REPORTING REQUIREMENT ENDORSEMENT - CALIFORNIA
WC990300B	WORKERS' COMPENSATION BROAD FORM ENDORSEMENT
WC990300C	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990300D	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990302B	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990303B	WORKERS COMPENSATION BROAD FORM ENDORSEMENT EXTENDED OPTIONS
WC990319D	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990324A	AMENDMENT TO EMPLOYERS LIABILITY STOP GAP COVERAGE ENDORSEMENT
WC990356A	AMENDMENT TO WORKERS COMPENSATION BROAD FORM ENDORSEMENT EXTENDED OPTIONS - EMPLOYERS LIABILITY STOP GAP COVERAGE

EXTENSION OF THE INFORMATION PAGE - ITEM 3.D - ENDORSEMENTS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Item 3.D. of the Information Page is completed to include the following endorsements:

WC990358B	AMENDMENT TO WORKERS COMPENSATION BROAD FORM ENDORSEMENT - EMPLOYERS LIABILITY STOP GAP COVERAGE
WC990359B	AMENDMENT TO WORKERS COMPENSATION BROAD FORM ENDORSEMENT - EMPLOYERS LIABILITY STOP GAP COVERAGE
WC990360	VIRGINIA COUNTERSIGNATURE EXCLUSION ENDORSEMENT
WC990365	EXTENSION OF THE INFORMATION PAGE - ITEM 1 - NAMED INSURED
WC990366	EXTENSION OF THE INFORMATION PAGE - ITEM 1 - OTHER WORKPLACES
WC990367	EXTENSION OF THE INFORMATION PAGE - ITEM 3.A - STATES COVERED
WC990368	EXTENSION OF THE INFORMATION PAGE - ITEM 3.D. - ENDORSEMENTS
WC990371A	ARIZONA COUNTERSIGNATURE EXCLUSION ENDORSEMENT
WC990375	CALIFORNIA INSTALLMENT FEE DISCLOSURE ENDORSEMENT
WC990380	WORKERS COMPENSATION BROAD FORM ENDORSEMENT
WC990689	GOODS AND SERVICES ENDORSEMENT
WC990694	GOODS AND SERVICES ENDORSEMENT
WC990696	Signature Page
WC990712	GOODS AND SERVICES ENDORSEMENT WASHINGTON

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

INSURER	NAIC	JURISDICTION
Hartford Fire Insurance Company ONE HARTFORD PLAZA HARTFORD CT 06155	19682	ID
Hartford Accident and Indemnity Company ONE HARTFORD PLAZA HARTFORD CT 06155	22357	IN OK OR
Trumbull Insurance Company ONE HARTFORD PLAZA HARTFORD CT 06155	27120	NV
Hartford Casualty Insurance Company ONE HARTFORD PLAZA HARTFORD CT 06155	29424	ME WI
Twin City Fire Insurance Company ONE HARTFORD PLAZA HARTFORD CT 06155	29459	WA NH DC OH MN IL CT RI MA LA FL UT NY CO GA IA AZ VA
Hartford Underwriters Insurance Company ONE HARTFORD PLAZA	HARTFORD CT 06155	30104

Nothing herein contained shall be held to vary, waive, alter or extend any of the terms, conditions, agreements or information of the policy, other than as herein stated.

This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement.

Countersigned by _____
Authorized Agent

TX NJ KS NC		
Property and Casualty Insurance Company of ONE HARTFORD PLAZA HARTFORD CT 06155	34690	CA
Hartford Insurance Company of the Midwest ONE HARTFORD PLAZA HARTFORD CT 06155	37478	PA

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-02-32

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
No Specific Location
PHOENIX AZ 85003

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, OR COLLECTORS - OUTSIDE	48,700.00	0.210000	102

Total State Summary

Total Class Premium			102
Emp liab increased limits		0.011000	1
Total Estimated Annual Standard Premium			103
Premium discount		0.030000	-3
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	48,700.00	0.010000	5
Catastrophe (other than certified acts of terrorism)	48,700.00	0.010000	5
Total Estimated Annual Premium			110

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY AND CASUALTY INSURANCE COMPANY OF HARTFORD

Company Code: P

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-04-01

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8859 COMPUTER PROGRAMMING OR SOFTWARE DEVELOPMENT - ALL EMPLOYEES - INCLUDING CLERICAL OFFICE EMPLOYEES, CLERICAL TELECOMMUTER EMPLOYEES AND OUTSIDE SALESPERSONS	2,159,600.00	0.050000	1,080

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY AND CASUALTY INSURANCE COMPANY OF HARTFORD

Company Code: P

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-04-02

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
1160 BATTERY ST
SAN FRANCISCO CA 94111

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8859 COMPUTER PROGRAMMING OR SOFTWARE DEVELOPMENT - ALL EMPLOYEES - INCLUDING CLERICAL OFFICE EMPLOYEES, CLERICAL TELECOMMUTER EMPLOYEES AND OUTSIDE SALESPERSONS	IF ANY	0.050000	0

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: PROPERTY AND CASUALTY INSURANCE COMPANY OF HARTFORD

Company Code: P

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-04-10

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
44 MONTGOMERY ST
SAN FRANCISCO CA 94104

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8859 COMPUTER PROGRAMMING OR SOFTWARE DEVELOPMENT - ALL EMPLOYEES - INCLUDING CLERICAL OFFICE EMPLOYEES, CLERICAL TELECOMMUTER EMPLOYEES AND OUTSIDE SALESPERSONS	IF ANY	0.050000	0

Total State Summary

Total Class Premium			1,080
CA Territorial Differential		0.688000	-337
Waiver of Subrogation		0.020000	250
Total Estimated Annual Standard Premium			993
Premium discount		0.028000	-28
Extended Broad Form Coverage		1.500000	15
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	2,159,600.00	0.020000	432
CA User Fund		1.927700	27
CA Fraud		0.485600	7
CA Uninsured Employers Benefit Trust Fund		0.145500	2
CA Subsequent Injuries Benefit Trust Fund Assessments		1.745100	25
CA Occupational Safety & Health Fund		0.917700	13
CA Labor Enforcement & Compliance Fund		0.710200	10
Total Estimated Annual Premium			1,496

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-05-03

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
3001 BRIGHTON BLVD STE 450
DENVER CO 80216

NAICS: 541511
FEIN: 38-3933355 SIC: 7371

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	IF ANY	0.200000	0
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	823,500.00	0.400000	3,294

Total State Summary

Total Class Premium			3,294
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	36
Designated Medical Provider Credit		2.500000	-90
Total Estimated Annual Standard Premium			3,490
Premium discount		0.028000	-98
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	823,500.00	0.011000	91
Catastrophe (other than certified acts of terrorism)	823,500.00	0.020000	165
Total Estimated Annual Premium			3,648

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-06-19

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
49 BEACON HILL DR
WATERFORD CT 06385

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	120,100.00	0.520000	625
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	168,200.00	0.210000	353

Total State Summary

Total Class Premium			978
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	11
Total Estimated Annual Standard Premium			1,239
Premium discount		0.028000	-35
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	288,300.00	0.025000	72
Catastrophe (other than certified acts of terrorism)	288,300.00	0.030000	86
Connecticut Special Assessment Fund (CBAI A8) Surcharge		1.900000	24
CT 2nd Injury Fund		2.250000	31
Total Estimated Annual Premium			1,417

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-08-18

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
770 5TH ST NW APT 304
WASHINGTON DC 20001

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8803 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: TRAVELING	92,600.00	0.050000	46
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	72,200.00	0.160000	116

Total State Summary

Total Class Premium			162
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	2
Total Estimated Annual Standard Premium			414
Premium discount		0.028000	-12
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	164,800.00	0.070000	115
Catastrophe (other than certified acts of terrorism)	164,800.00	0.020000	33
Total Estimated Annual Premium			550

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-09-13

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
18914 ROGERS RD
ODESSA FL 33556

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	80,200.00	0.320000	257

Total State Summary

Total Class Premium			257
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.014000	4
Total Estimated Annual Standard Premium			511
Premium discount		0.030000	-15
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	80,200.00	0.010000	8
Total Estimated Annual Premium			504

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-10-04

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
1321 MERRY ST
AUGUSTA GA 30904

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	170,300.00	0.230000	392
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	24,600.00	0.490000	121

Total State Summary

Total Class Premium			513
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	6
Total Estimated Annual Standard Premium			769
Premium discount		0.028000	-22
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	194,900.00	0.005000	10
Catastrophe (other than certified acts of terrorism)	194,900.00	0.030000	58
Total Estimated Annual Premium			815

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD FIRE INSURANCE COMPANY

Company Code: 1

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-11-17

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
4805 N ARROW VILLA WAY
BOISE ID 83703

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	336,700.00	0.330000	1,111
8803 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: TRAVELING	93,200.00	0.080000	75

Total State Summary

Total Class Premium			1,186
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	13
Total Estimated Annual Standard Premium			1,449
Premium discount		0.030000	-43
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	429,900.00	0.010000	43
Catastrophe (other than certified acts of terrorism)	429,900.00	0.010000	43
Total Estimated Annual Premium			1,492

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-12-15

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
987 BLUE ASTER PKWY
GILBERTS IL 60136

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	222,400.00	0.520000	1,156
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	218,100.00	0.230000	502

Total State Summary

Total Class Premium			1,658
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.014000	23
Total Estimated Annual Standard Premium			1,931
Premium discount		0.028000	-54
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	440,500.00	0.065000	286
Catastrophe (other than certified acts of terrorism)	440,500.00	0.030000	132
IL Industrial Commission Operations Fund Surcharge		1.010000	23
Total Estimated Annual Premium			2,318

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD ACCIDENT AND INDEMNITY COMPANY

Company Code: 5

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-13-29

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
9402 GRANDVIEW CT
NOBLESVILLE IN 46060

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	146,700.00	0.110000	161
Total State Summary			
Total Class Premium			161
Emp liab increased limits		0.011000	2
Total Estimated Annual Standard Premium			163
Premium discount		0.030000	-5
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	146,700.00	0.006000	9
Catastrophe (other than certified acts of terrorism)	146,700.00	0.010000	15
IN 2nd Injury Fund Assessment (CBAI D7)		0.840000	2
Total Estimated Annual Premium			184

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-14-30

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
2215 IRONWOOD CT
AMES IA 50014

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	240,900.00	0.200000	482

Total State Summary

Total Class Premium			482
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	5
Total Estimated Annual Standard Premium			737
Premium discount		0.030000	-22
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	240,900.00	0.010000	24
Catastrophe (other than certified acts of terrorism)	240,900.00	0.010000	24
Total Estimated Annual Premium			763

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-15-20

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
5306 W 80TH TER
PRAIRIE VILLAGE KS 66208

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	54,600.00	0.370000	202
8810 CLERICAL OFFICE EMPLOYEES NOC	137,500.00	0.170000	234

Total State Summary

Total Class Premium			436
Emp liab increased limits		0.011000	5
Total Estimated Annual Standard Premium			441
Premium discount		0.028000	-12
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	192,100.00	0.012000	23
Catastrophe (other than certified acts of terrorism)	192,100.00	0.020000	38
Total Estimated Annual Premium			490

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-17-21

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
863 FARENZIE RD
COLFAX LA 71417

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	55,100.00	0.550000	303
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	98,600.00	0.240000	237

Total State Summary

Total Class Premium			540
Emp liab increased limits		0.014000	8
Total Estimated Annual Standard Premium			548
Premium discount		0.028000	-15
Waiver of Subrogation		0.020000	250
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	153,700.00	0.009000	14
Catastrophe (other than certified acts of terrorism)	153,700.00	0.020000	31
Total Estimated Annual Premium			828

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-18-28

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
10 SOUTHGATE WAY
ELLSWORTH ME 04605

FEIN: 38-3933355 UIN : 1800000000 NAICS: 541511 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	69,100.00	0.270000	187
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	3,100.00	0.470000	15

Total State Summary

Total Class Premium			202
Emp liab increased limits		0.011000	2
Merit Rating		0.920000	-16
Total Estimated Annual Standard Premium			188
Premium discount		0.028000	-5
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	72,200.00	0.009000	6
Catastrophe (other than certified acts of terrorism)	72,200.00	0.020000	14
ME Administrative Fund Assessment (CBAI B2)		2.480000	5
Total Estimated Annual Premium			208

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-20-05

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
26 RICE SPRING LN
WAYLAND MA 01778

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	1,611,700.00	0.060000	967
8742 SALESPERSONS, COLLECTORS OR MESSENGERS - OUTSIDE	72,700.00	0.090000	65
Total State Summary			
Total Class Premium			1,032
Waiver of Subrogation		0.020000	21
Emp liab increased limits		0.020000	21
Merit Rating		0.950000	-54
Total Estimated Annual Standard Premium			1,020
Premium discount		0.030000	-31
Expense constant			338
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	1,684,400.00	0.030000	505
MA DIA Private/Public Assessment (CBAI 62) Surcharge		4.180000	41
Total Estimated Annual Premium			1,873

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TRUMBULL INSURANCE COMPANY

Company Code: H

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-27-11

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
2456 N 21ST WEST ST
ELY NV 89301

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	IF ANY	0.190000	0

Total State Summary

Total Class Premium		0
Waiver of Subrogation	0.020000	50
Total Estimated Annual Standard Premium		50
Premium discount	0.087000	-4
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	0.048000	0
Catastrophe (other than certified acts of terrorism)	0.010000	0
Total Estimated Annual Premium		46

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-28-16

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
14 LAKESHORE RD
WINDHAM NH 03087

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	189,700.00	0.140000	266

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-28-24

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
5 COLONEL WILKINS RD
AMHERST NH 03031

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 4

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	209,500.00	0.140000	293
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	389,300.00	0.290000	1,129

Total State Summary

Total Class Premium			1,688
Emp liab increased limits		0.011000	19
Total Estimated Annual Standard Premium			1,707
Premium discount		0.028000	-48
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	788,500.00	0.008000	63
Catastrophe (other than certified acts of terrorism)	788,500.00	0.020000	158
Total Estimated Annual Premium			1,880

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-29-14

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
105 HIGHLAND AVE
NEWARK NJ 07104

FEIN: 38-3933355 TIN : NJ 383933350500 NAICS: 541511 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8803 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: TRAVELING	174,000.00	0.100000	174

Total State Summary

Total Class Premium			174
Emp liab increased limits		0.014000	2
Total Estimated Annual Standard Premium			176
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	174,000.00	0.030000	52
Catastrophe (other than certified acts of terrorism)	174,000.00	0.010000	17
NJ Surcharges 2nd Injury Fund		5.330000	9
NJ Uninsured Employers Fund			0
Total Estimated Annual Premium			254

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-31-25

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
105 HIGHLAND AVE
NEWARK NY 14513

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS OR MESSENGERS - OUTSIDE	IF ANY	0.360000	0
8810 CLERICAL OFFICE EMPLOYEES NOC	IF ANY	0.160000	0

Total State Summary

Total Class Premium		0
Waiver of Subrogation	0.020000	250
Merit Rating	0.920000	-20
Total Estimated Annual Standard Premium		230
Premium discount	0.030000	-7
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	0.041000	0
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement - NY Percapita		0
Catastrophe (other than certified acts of terrorism)	0.007000	0
Catastrophe (other than certified acts of terrorism) -NY Percapita Classes		0
New York State Assessment	10.200000	23
Total Estimated Annual Premium		246

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-32-12

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
3909 STERLING RIDGE LN
DURHAM NC 27707

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	75,200.00	0.160000	120
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	727,700.00	0.370000	2,692

Total State Summary

Total Class Premium			2,812
Waiver of Subrogation		0.020000	100
Emp liab increased limits		0.011000	31
Total Estimated Annual Standard Premium			2,943
Premium discount		0.028000	-82
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	802,900.00	0.011000	88
Catastrophe (other than certified acts of terrorism)	802,900.00	0.020000	161
Total Estimated Annual Premium			3,110

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-34-31

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
NO SPECIFIC LOCATION
IN STATE OF OH

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
9139 STOP GAP	166,610.00	0.020000	250

Total State Summary

Total Class Premium			250
Emp liab increased limits		0.011000	3
Total Estimated Annual Standard Premium			253
Total Estimated Annual Premium			253

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD ACCIDENT AND INDEMNITY COMPANY

Company Code: 5

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-35-23

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
4401 S BANNER RD
EL RENO OK 73036

NAICS: 541511
FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	115,200.00	0.440000	507

Total State Summary

Total Class Premium			507
Emp liab increased limits		0.014000	7
Merit Rating		0.950000	-26
Total Estimated Annual Standard Premium			488
Premium discount		0.028000	-14
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	115,200.00	0.009000	10
Catastrophe (other than certified acts of terrorism)	115,200.00	0.020000	23
Total Estimated Annual Premium			507

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD ACCIDENT AND INDEMNITY COMPANY

Company Code: 5

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-36-27

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
1718 SE 30TH AVE
PORTLAND OR 97214

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	11,000.00	0.240000	26
8810 CLERICAL OFFICE EMPLOYEES NOC	240,900.00	0.120000	289

Total State Summary

Total Class Premium			315
Emp liab increased limits		0.004000	1
Total Estimated Annual Standard Premium			316
Premium discount		0.028000	-9
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	251,900.00	0.010000	25
Catastrophe (other than certified acts of terrorism)	251,900.00	0.020000	50
OR Administrative Fund Assessment		9	34
Total Estimated Annual Premium			416

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD INSURANCE COMPANY OF THE MIDWEST

Company Code: G

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-37-33

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
1325 N 5TH ST
PHILADELPHIA PA 19122

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
0953 CLERICAL OFFICE EMPLOYEES	99,000.00	0.230000	228

Total State Summary

Total Class Premium			228
Emp liab increased limits		0.014000	3
Waiver of Subrogation		0.020000	250
Total Estimated Annual Standard Premium			481
Premium discount		0.028000	-13
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	99,000.00	0.070000	69
Catastrophe (other than certified acts of terrorism)	99,000.00	0.030000	30
PA Assessment Surcharge		2.680000	15
Total Estimated Annual Premium			582

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-38-07

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
48 BAINBRIDGE AVE
PROVIDENCE RI 02909

FEIN: 38-3933355 TIN : RI 0002582929 NAICS: 541511 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	145,100.00	0.480000	696
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	IF ANY	0.210000	0

Total State Summary

Total Class Premium			696
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	8
Total Estimated Annual Standard Premium			954
Premium discount		0.030000	-29
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	145,100.00	0.010000	15
Catastrophe (other than certified acts of terrorism)	145,100.00	0.020000	29
Total Estimated Annual Premium			969

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD UNDERWRITERS INSURANCE COMPANY

Company Code: 6

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-42-08

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
5501 PORSCHE LN
AUSTIN TX 78749

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 COMPUTER AND DATA PROCESSING SERVICES: OPERATORS, PROGRAMMERS	IF ANY	0.080000	0
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	IF ANY	0.160000	0

Total State Summary

Total Class Premium			0
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement		0.024000	0
Catastrophe (other than certified acts of terrorism)			0

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-43-26

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
734 E CHRISTENSEN CT
SALT LAKE CITY UT 84106

NAICS: 541511

FEIN: 38-3933355 UIN : 3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS OR COLLECTORS - OUTSIDE	17,500.00	0.260000	46
8810 CLERICAL OFFICE EMPLOYEES NOC	83,800.00	0.100000	84

Total State Summary

Total Class Premium			130
Emp liab increased limits		0.011000	1
Total Estimated Annual Standard Premium			131
Premium discount		0.028000	-4
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	101,300.00	0.010000	10
Catastrophe (other than certified acts of terrorism)	101,300.00	0.020000	20
Total Estimated Annual Premium			157

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-45-09

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
25429 JUBILANT DR
ALDIE VA 20105

NAICS: 541511

FEIN: 38-3933355 SIC: 7371

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	306,000.00	0.190000	581
8810 CLERICAL OFFICE EMPLOYEES NOC	IF ANY	0.090000	0

Total State Summary

Total Class Premium			581
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	6
Total Estimated Annual Standard Premium			837
Premium discount		0.028000	-23
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	306,000.00	0.060000	184
Total Estimated Annual Premium			998

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-46-22

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
15318 NE 13TH PL APT B225
BELLEVUE WA 98007

NAICS: 541511
FEIN: 38-3933355 SIC: 7371

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
9139 STOP GAP	83,000.00	0.020000	250

Total State Summary

Total Class Premium			250
Emp liab increased limits		0.011000	3
Total Estimated Annual Standard Premium			253
Total Estimated Annual Premium			253

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: HARTFORD CASUALTY INSURANCE COMPANY

Company Code: 3

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-48-34

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
2421 N 60TH ST
WAUWATOSA WI 53210

NAICS: 541511

FEIN: 38-3933355 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8810 CLERICAL OFFICE EMPLOYEES NOC	146,700.00	0.190000	279

Total State Summary

Total Class Premium			279
Emp liab increased limits		0.011000	3
Waiver of Subrogation		0.020000	50
Total Estimated Annual Standard Premium			332
Premium discount		0.054000	-18
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	146,700.00	0.020000	29
Catastrophe (other than certified acts of terrorism)	146,700.00	0.010000	15
Total Estimated Annual Premium			358

Countersigned by _____

Authorized Representative

SCHEDULE OF OPERATIONS

This Schedule of Operations forms a part of the policy effective on the inception date of the policy unless another date is indicated below:

INSURER: TWIN CITY FIRE INSURANCE COMPANY

Company Code: 7

Policy Number: 08 WEC AP8931 **Schedule Number:** 01-22-06

Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.

Named Insured and Location Address of operations covered by this schedule:

CAMUNDA INC
3014 40TH AVE S
MINNEAPOLIS MN 55406

NAICS: 541511

FEIN: 38-3933355 UAN : MN 9999999999 SIC: 7371 NO. OF EMPL: 1

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.

Classifications Code Number and Description	Premium Basis Total Estimated Annual Remuneration	Rates Per $100 of Remuneration	Estimated Annual Premium
8742 SALESPERSONS, COLLECTORS, OR MESSENGERS - OUTSIDE	175,000.00	0.550000	963
8810 COMPUTER SYSTEM DESIGNERS OR PROGRAMMERS: EXCLUSIVELY OFFICE	154,100.00	0.230000	354

Total State Summary

Total Class Premium			1,317
Waiver of Subrogation		0.020000	250
Emp liab increased limits		0.011000	14
Total Estimated Annual Standard Premium			1,581
Premium discount		0.028000	-44
Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement	329,100.00	0.016000	53
MN Special Compensation Fund Assessment (CBAI 72)		2.900000	47
Total Estimated Annual Premium			1,637

Countersigned by _____
Authorized Representative

THIS LETTER CONTAINS IMPORTANT INFORMATION. PLEASE READ CAREFULLY AND RETAIN THIS LETTER FOR FUTURE USE.

Texas Regional Office
450 Gears Road, Suite 500
Houston, TX 77067-4585
P.O. Box 4611
Houston, TX 77210-4611
Telephone (281) 874-9600

TO: WORKERS' COMPENSATION POLICYHOLDERS IN TEXAS

Thank you for choosing The Hartford as your workers' compensation carrier. We ask that you take a minute to familiarize yourself with the forms and reporting requirements for the State of Texas which we have included in this packet.

1. Each employer should maintain a record of all injuries reported or made known to the employer. The Texas Department of Insurance, Division of Workers' Compensation (DWC) may at times request these records for review.

2. If the injury causes an employee to be off work more than one day **OR** involve a claim for an occupational disease you must immediately report the loss.

3. Please refer to Form WC 66 02 51 for LossConnect loss reporting instructions.

4. LossConnect will file all necessary state reports.

5. THE CLAIM MUST BE REPORTED NO LATER THAN THE EIGHTH DAY AFTER THE LOSS OF ONE DAY OF WORK OR THE FIRST NOTICE OF AN OCCUPATIONAL DISEASE. FAILURE TO COMPLY MAY RESULT IN AN ADMINISTRATIVE VIOLATION WHICH COULD INCLUDE UP TO A $500.00 FINE.

6. The FROI must be filed even on a doubtful or disputed claim. Your lack of knowledge of the claim details should be reflected on the report.

COMPLETION OF A FROI IS NOT CONSIDERED AN ADMISSION OF OR EVIDENCE OF A COMPENSABLE INJURY IF THE FACTS CONTAINED THEREIN ARE LATER CONTRADICTED.

7. The Employer's Wage Statement (DWC-3) should be provided to the carrier, employee, and DWC if you know or expect 8 days of disability.

8. The Supplemental Report of Injury (DWC-6) should be filed with the carrier whenever you (as the employer) are aware of any change in work status or earnings due to the injury. DO NOT SEND TO THE DWC.

We, as the carrier, cannot act quickly and efficiently in your interest unless immediate notice of an injury is received. Your cooperation is imperative and we stand to assist you in any way we can.

Form WC 55 00 22 A Printed in U.S.A.

The Hartford Insurance Group
Hartford Fire Insurance Company and its Affiliates
Hartford Plaza, Hartford, Connecticut 06115

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY QUICK REFERENCE

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

PLEASE READ THE WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

Form WC 66 01 56 B Printed in U.S.A.
Process Date: 07/02/22 **Policy Expiration Date:** 08/11/23

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 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 Noappropriated 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 cancelled, final premium will be determined in the following way unless our manuals provide otherwise:

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

F. Records

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

G. Audit

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

PART SIX - CONDITIONS

A. Inspection

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

B. Long Term Policy

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

C. Transfer of Your Rights and Duties

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

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

D. Cancellation

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

E. Sole Representative

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS INSURANCE FOR ANY REASON, PLEASE CONTACT YOUR HARTFORD AGENT. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number.

SERVICING OFFICE:

THE HARTFORD
BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
(866) 467-8730

If you have been unable to contact or obtain satisfaction from the agent or from The Hartford's servicing office, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the address below.

VIRGINIA BUREAU OF INSURANCE
P.O. Box 1157
Richmond, VA 23218
Telephone: (804) 371-9185
1-800-552-7945 (Virginia Residents Only)

Written correspondence is preferable so that a record of your inquiry is maintained.

WHEN CONTACTING YOUR AGENT, COMPANY OR THE BUREAU OF INSURANCE, HAVE YOUR POLICY NUMBER AVAILABLE.

IMPORTANT NOTICE FOR FLORIDA POLICYHOLDERS

If you would like to present inquiries or obtain information about coverage or obtain assistance in resolving a complaint, please contact YOUR HARTFORD AGENT, or you may contact The Hartford at the number stated below.

SERVICING OFFICE:

THE HARTFORD BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
TELEPHONE: (866) 467-8730

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE BE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

IMPORTANT INFORMATION FOR ILLINOIS POLICYHOLDERS

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS POLICY, PLEASE CONTACT YOUR HARTFORD AGENT.

If you have a complaint, you may contact The Hartford at the address stated below.

The Hartford
Customer Relations Department
Hartford Plaza
Hartford, CT 06115
Telephone: 1-800-727-0721

If you have been unable to contact or obtain satisfaction from your agent or from The Hartford's Customer Relations Department, you may contact the Illinois Department of Insurance at the address below.

ILLINOIS DEPARTMENT OF INSURANCE
Consumer Services Section
Springfield, IL 62767

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE MAKE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

IMPORTANT INFORMATION FOR UTAH POLICYHOLDERS

IN THE EVENT YOU NEED TO CONTACT SOMEONE ABOUT THIS POLICY, PLEASE CONTACT YOUR HARTFORD AGENT. If you have additional questions, you may contact The Hartford at the address stated below.

SERVICING OFFICE:

THE HARTFORD BUSINESS SERVICE CENTRE
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
TELEPHONE: (866) 467-8730

Written correspondence is preferable so that a record of your inquiry is maintained.

PLEASE MAKE SURE TO INCLUDE YOUR POLICY NUMBER IN ANY CORRESPONDENCE.

POLICYHOLDER NOTICE

CALIFORNIA WORKERS' COMPENSATION INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws.

1. We establish our own rates for workers' compensation. Our rates, rating plans, and related information are filed with the insurance commissioner and are open for public inspection.

2. The insurance commissioner can disapprove our rates, rating plans, or classifications only if he or she has determined after public hearing that our rates might jeopardize our ability to pay claims or create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance commissioner disapproves our rates, rating plans, or classifications, he or she may order an increase in the rates applicable to outstanding policies.

3. Rating organizations may develop pure premium rates that are subject to the insurance commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per $100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to use the pure premium rates developed by any rating organization in establishing our own rates.

4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan, which is developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner.

5. A standard classification system, developed by the insurance rating organization designated by the insurance commissioner, is subject to approval by the insurance commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided we can report the payroll, expenses, and other costs of claims in a way that is consistent with the uniform statistical plan or the standard classification system.

6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.

7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process requires us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the insurance commissioner.

CALIFORNIA WORKERS' COMPENSATION INSURANCE
NOTICE OF NONRENEWAL

Section 11664 of the California Insurance Code requires us, in most instances, to provide you with a notice of nonrenewal. Except as specified in paragraphs 1 through 6 below, if we elect to nonrenew your policy, we are required to deliver or mail to you a written notice stating the reason or reasons for the nonrenewal of the policy. The notice is required to be sent to you no earlier than 120 days before the end of the policy period and no later than 30 days before the end of the policy period. If we fail to provide you the required notice, we are required to continue the coverage under the policy with no change in the premium rate until 60 days after we provide you with the required notice.

We are not required to provide you with a notice of nonrenewal in any of the following situations:

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.

2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

3. You obtained replacement coverage or agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.
5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

6. We made a written offer to you to renew the policy at a premium rate increase of less than 25 percent.

   (A) If the premium rate in your governing classification is to be increased 25 percent or greater and we intend to renew the policy, we shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with California Insurance Code 11750.3(c).

   (B) For purposes of this Notice, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

This notice does not change the policy to which it is attached.

IMPORTANT NOTICE

Minnesota State Workmen's Compensation Law requires that compensation payments to injured workers begin within fourteen days after the first day of disability. If the Industrial Commission should find that a delay was due to your failure to report a claim to the company they would insist on the **penalty being paid by you and would not permit your insurance company to reimburse you.**

To avoid any possibility of a substantial penalty, report all accidents and claims to our claim representative immediately. If you are unable to contact our claim representative, notify your agent and ask him to see that the claim report is made out and filed without delay.

IMPORTANT NOTICE

Please read carefully and retain for future reference.

To Workers' Compensation Policyholders - State of Connecticut

1. Under the Workers' Compensation Law you are required to make an immediate report in duplicate (Employer's Report of Injury), of all injuries occurring in the course of employment. An injury to be reported must:
   A. Cause loss of time from regular work for one day or more, or
   B. Require treatment beyond first aid, i.e. outside treatment by a physician.
   C. Serious or fatal injuries should be reported to the carrier at once, by telephone.

   Failure of employer to make a prompt report, or to conform to any of the provisions of the Compensation Law may subject the employer to a $250 fine for each such failure. **This fine is assessed directly against** the employer, (Sec. 31-288).

2. Under the Workers' Compensation Law, the insurance carrier on behalf of the employer must:
   A. Pay any compensation due, **within ten days** (Sec. 31-303)
   B. Contest the claim on or before the 20th day following the date of the employer's knowledge of the injury, (Sec. 31-297).

3. To avoid delay in paying benefits, the Employer's Report of Injury must accurately state the employee's earnings. To avoid overpayment, immediately notify the carrier when the employee returns to work.

   The law specifies that notice to employer is notice to carrier. We, as the carrier, cannot act quickly and efficiently in your interest, unless prompt notice of an injury is received. Your cooperation is earnestly solicited.

Form WC 66 00 52 A Printed in U.S.A.

WORKERS' COMPENSATION DISCLOSURE FORM

IMPORTANT NOTICE TO POLICYHOLDERS

1. NOTICE OF CHANGE IN RATE BY CLASSIFICATION

If you desire information whenever there is a change in your workers' compensation insurance rate by classification, you must request such information from your insurer. This request for information must be in writing.

2. NOTICE OF POLICYHOLDER'S RIGHT TO APPEAL CLASSIFICATION

Your insurer can charge and collect any additional amount of money not included in the initial premium charged as a result of job misclassification.

If you have any questions regarding the employee classification assigned to calculate your workers' compensation insurance premium, you need to direct your questions to your insurer or the insurer's authorized representative within either thirty (30) days after the anniversary date of the policy or the date of receipt by you of notice of a change in job classification. Within thirty (30) days after receipt of your request for information, your insurer or the insurer's authorized representative must explain to you why a particular employee classification was used.

If you disagree with your insurer or the insurer's authorized representative on the employee classification assignment, you may appeal to the Workers' Compensation Classification Appeal Board by filing written notice with said board within thirty (30) days after you have exhausted all appeal review procedures provided by the insurer. Your request should be sent to the Secretary of the Colorado Workers' Compensation Classification Appeals Board, Michael Craddock, c/o National Council on Compensation Insurance, 901 Peninsula Corporate Circle, Boca Raton, FL 33487. Written instructions for your appearance before the Colorado Workers' Compensation Classification Appeals Board will be furnished by the Secretary of the board. The board will render a decision as to whether a misclassification has occurred.

A decision by the board is final and not subject to appeal unless you, the insurer or Pinnacol Assurance provides written notice of appeal within thirty (30) days after the board's decision to the office of the Commissioner of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. The Commissioner shall review any decision of the board properly appealed.

3. NOTICE OF AVAILABILITY OF MEDICAL CASE MANAGEMENT SERVICES

On appropriate cases, staff Health Service Representatives (R.N.'s) or outside vendors are assigned for medical case management to insure quality medical care and rehabilitation at a reasonable cost. The use includes, but is not limited to, coordinating with qualified medical providers, monitoring the rehabilitation process and working with employers to return the injured party to their regular or a modified position.

IMPORTANT NOTICE TO OUR POLICYHOLDERS

As required by Florida law, statute number 440.381, paragraph 4, you are required to file with your insurance carrier on a quarterly basis: UCT-6 and a current list of employees.

Failure to do so, could result in your policy being cancelled.

If you have any questions, please contact your Insurance Agent.

IMPORTANT NOTICE
Effective July 1, 1978

The Georgia Workers' Compensation Law requires that compensation payments to injured workers begin within fourteen days after the employer has knowledge of the accident. If a delay is due to your failure to report a claim to the company the penalty will be paid by you. Your Insurance carrier will not reimburse you.

To avoid any possibility of a substantial penalty, report all accidents and claims to our claims representative immediately. If you are unable to contact our claim representative, notify your agent and ask him/her to see that the claim report is made out and filed without delay

Form WC 66 02 75 Printed in U.S.A.

IMPORTANT NOTICE

THE NEW HAMPSHIRE STATE WORKER'S COMPENSATION LAW REQUIRES THAT A WRITTEN EMPLOYER'S REPORT OF INJURY BE MADE WITHIN FIVE DAYS

AN EMPLOYER WHO FAILS TO COMPLY IS SUBJECT TO A PENALTY OF UP TO $2,500.

IMPORTANT NOTICE

Chapter 525, Section 110 of the New York Workers' Compensation Law requires that a written Employer's Report of Work-Related Accident/Occupational Disease (Form C-2) be made in ten days after the occurrence of an accident.

An employer who fails to comply with this requirement is subject to a fine of up to $2,500 and up to one year imprisonment.

Policyholder Notice: Illinois

Based on what we know at this time – including underwriting information we have on file, state requirements, current rate plans and more – you can expect the following:

NOTICE OF RENEWAL PREMIUM CHANGE

Your expiring premium is $27,723. The estimated premium for your renewal policy will be $28,362. We are required to advise you that had we followed the industry recommended rate change in Illinois, your premium would have been $28,151 or $211 lower. The reason for the increase is based on our general loss experience in the state and your risk characteristics.

The renewal terms described here may change as we get closer to your renewal date. If there are any additional changes we'll notify you under separate cover. If you have questions about this notice or your policy, please contact your insurance agent or broker, or contact us directly.

Thank you for choosing The Hartford to be your insurance provider. We look forward to continuing to provide coverage that meets your insurance needs.

IMPORTANT NOTICE TO OUR OREGON POLICYHOLDERS

OREGON INSURANCE GUARANTY ASSOCIATION SURCHARGE

Most insurers doing business in Oregon participate in the Oregon Insurance Guaranty Association (OIGA). In the event an insurer fails, the Association settles unpaid claims on behalf of consumers. Oregon law requires that policies be surcharged directly to recover the costs of handling those claims.

If your policy is surcharged, the term "OIGA Surcharge" along with an indicated dollar amount will be displayed with the statement of your surcharge.

If you have any questions, please contact your Hartford agent, broker or representative.

Insurance Policy Billing Information

Thank you for selecting The Hartford for your business insurance needs.

Shortly, you will receive your first bill from us. You are receiving this Notice so you know what to expect as a valued customer of The Hartford. Should you have any questions after reviewing this information, please contact us at 866-467-8730, and we will be happy to assist you.

- Your total policy premium will appear on your policy's Declarations Page. You will be billed based on the payment plan you selected.
- You may pay the "minimum due" as it appears on your insurance bill or pay the policy balance in full.
- An installment service fee is added to each installment. A late fee will also be applied if the "minimum due" is not **received** by the due date shown on your bill. Service and late payment fees do not apply in all states.
- If you selected installment billing, any credit or additional premium due as the result of a change made to your policy, will be spread over the remaining billing installments. Additional premium due as a result of an **audit** will be billed in full on your next bill date following the completion of the audit.
- If you elected Electronic Funds Transfer (EFT), policy changes may result in changes to the amount automatically withdrawn from your bank account. The invoice you receive following a policy change will include future withdrawal amounts. If you need to adjust or stop your next scheduled EFT withdrawal, please contact us **at least 3 days prior** to the scheduled withdrawal date at the telephone number shown below.
- If you selected installment billing and pay the premiums for your first policy term on time, at renewal, your account may qualify for our "Equal Installment" feature. This means that the percentage due for each installment, including the initial renewal installment, will be the same throughout the policy term – helping you better manage cash flow. Equal installments will continue as long as you pay your premiums on time and no cancellation notices are issued for any policy on your account. If you no longer qualify for Equal Installments, future renewals will be billed based on the payment plan you selected, which includes a higher initial installment amount.
- If your policy is eligible for renewal, your bill for the upcoming policy term will be sent to you approximately 30 days prior to your policy's renewal date. If your insurance needs change, please contact us at least 60 days prior to your renewal date so we can properly address any adjustments needed.
- **One bill convenience** -- you have the option of combining all eligible Hartford policies on one single bill allowing you to make one payment for all policies on your account as payments are due.

You're In Control

In addition to selecting a bill plan option that best meets your budget, you have the flexibility to decide ***how*** your payments are made …

- **Repetitive EFT:** Sign up for Repetitive EFT payments and have payments automatically withdrawn from your bank account. This option saves you money by reducing the amount of the installment service fee.
- **Pay Online:** Register at **www.thehartford.com/servicecenter.** Online Bill Pay is Quick, Easy and Secure!
- **Pay by Check:** Send a check with your remittance stub in the envelope provided with your bill.
- **Pay by Phone:** Call toll-free **1-866-467-8730.**

Should you have any questions about your bill, please call Customer Service toll-free number:
1-866-467-8730 - 7AM – 7PM CST. We look forward to being of service to you.

Form 100722 11th Rev. Printed in U.S.A.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS - ASSESSMENT CHARGE

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Massachusetts General Laws, Chapter 152, Section 65, as amended by Chapter 572 of the Acts of 1985, establishes a workers compensation special fund and a workers compensation trust fund.

On behalf of the Department of Industrial Accidental (DIA), the insurance company providing workers compensation coverage is required to bill and collect an assessment charge covering the special and trust funds from insured employers and remit the amounts collected to the State Treasury.

The assessment charge, which is determined by applying a rate (subject to annual change) to the **DIA's** standard premium, **as defined and outlined in 452 CMR 7.00**, developed under your policy, is shown as a separate item on the information page of the policy. The rate may be different for private employers and for the Commonwealth and its political subdivisions.

The income derived from the assessment charge will be used to fund the operating expenses of the DIA and to fund certain employee benefits as described in Chapter 152.

POLICYHOLDER NOTICE
YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us - Property and Casualty Insurance Company of Hartford

(1) General questions regarding your policy should be directed to **your Hartford Agent or**

Property and Casualty Insurance Company of Hartford
3600 Wiseman Blvd
San Antonio, TX 78251
Telephone: (866) 467-8730
agency.services@thehartford.com
www.thehartford.com

(2) **Dividend Calculation.** If this is a participating policy (a policy on which a dividend may be paid), upon payment or non-payment of a dividend, we shall provide a written explanation to you that sets forth the basis of the dividend calculation. The explanation will be in clear, understandable language and will express the dividend as a dollar amount and as a percentage of the earned premium for the policy year on which the dividend is calculated.

(3) **Claims Information.** Pursuant to Sections 3761 and 3762 of the California Labor Code, you are entitled to receive information in our claim files that affects your premium. Copies of documents will be supplied at your expense during reasonable business hours.

For claims covered under this policy, we will estimate the ultimate cost of unsettled claims for statistical purposes eighteen months after the policy becomes effective and will report those estimates to the Workers' Compensation Insurance Rating Bureau of California (WCIRB) no later than twenty months after the policy becomes effective. The cost of any settled claims will also be reported at that time. At twelve-month intervals thereafter, we will update and report to the WCIRB the estimated cost of any unsettled claims and the actual final cost of any claims settled in the interim. The amounts we report will be used by the WCIRB to compute your experience modification if you are eligible for experience rating.

B. Information Available from the Workers' Compensation Insurance Rating Bureau of California

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan—1995* (USRP) and the *California Workers' Compensation Experience Rating Plan—1995* (ERP). WCIRB contact information is: WCIRB, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Customer Service; 888.229.2472 (phone); 415.778.7272 (fax); and customerservice@wcirb.com (email). The regulations contained in the USRP and ERP are available for public viewing through the WCIRB's website at wcirb.com.

(2) **Policyholder Information.** Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

(3) **Experience Rating Form.** Each experience rated risk may receive a single copy of its current Experience Rating Form/Worksheet free of charge by completing a Policyholder Experience Rating Worksheet Request Form on the WCIRB's website at wcirb.com/ratesheet. The Experience Rating Form/Worksheet will include a Loss-Free Rating, which is the experience modification that would have been calculated if $0 (zero) actual losses were incurred during the experience period. This hypothetical rating calculation is provided for informational purposes only.

II. Dispute Process

You may dispute our actions or the actions of the WCIRB pursuant to CIC Sections 11737 and 11753.1.

A. Our Dispute Resolution Process.

You may send us a written Complaint and Request for Action requesting that we reconsider a change in a classification assignment that results in an increased premium and/or requesting that we review the manner in which our rating system has been applied in connection with the insurance afforded or offered you. Written Complaints and Requests for Action should be forwarded to:
Property and Casualty Insurance Company of Hartford
One Pointe Drive, Suite 200, Brea, CA 92821; Telephone (800) 451-6944; Fax (860) 723-4289.

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether your written request will be reviewed. If we agree to review your request, we must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If we decline to review your request, if you are dissatisfied with the decision upon review, or if we fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below.

B. Disputing the Actions of the WCIRB. If you have been aggrieved by any decision, action, or omission to act of the WCIRB, you may request, in writing, that the WCIRB reconsider its decision, action, or omission to act. You may also request, in writing, that the WCIRB review the manner in which its rating system has been applied in connection with the insurance afforded or offered you. For requests related to classification disputes, the reporting of experience, or coverage issues, your initial request for review must be received by the WCIRB within 12 months after the expiration date of the policy to which the request for review pertains, except if the request involves the application of the Revision of Losses rule. For requests related to your experience modification, your initial request for review must be received by the WCIRB within 6 months after the issuance, or 12 months after the expiration date, of the experience modification to which the request for review pertains, whichever is later, except if the request for review involves the application of the Revision of Losses rule. If the request involves the Revision of Losses rule, the time to state your appeal may be longer. (See Section VI, Rule 7 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: **WCIRB, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Customer Service. Customer Service can be reached at 888.229.2472 (phone), 415.778.7272 (fax) and customerservice@wcirb.com (email).**

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether your written request will be reviewed. If the WCIRB agrees to review your request, it must conduct the review and issue a decision granting or rejecting your request within 60 days after sending you the written notice granting review. If the WCIRB declines to review your request, if you are dissatisfied with the decision upon review, or if the WCIRB fails to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner as described in paragraph II.C., below. Written Complaints and Requests for Action should be forwarded to: **WCIRB, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).**

C. California Department of Insurance – Appeals to the Insurance Commissioner. After you follow the appropriate dispute resolution process described above, if (1) we or the WCIRB decline to review your request, (2) you are dissatisfied with the decision upon review, or (3) we or the WCIRB fail to grant or reject your request or issue a decision upon review, you may appeal to the Insurance Commissioner pursuant to CIC Sections 11737, 11752.6, 11753.1 and Title 10, California Code of Regulations, Section 2509.40 et seq. You must file your appeal within 30 days after we or the WCIRB send you the notice rejecting review of your Complaint and Request for Action or the decision upon your Complaint and Request for Action. If no written decision regarding your Complaint and Request for Action is sent, your appeal must be filed within 120 days after you sent your Complaint and Request for Action to us or to the WCIRB. The filing address for all appeals to the Insurance Commissioner is:

Administrative Hearing Bureau
California Department of Insurance
1901 Harrison Street, 3rd Floor Mailroom
Oakland, CA 94612
415.538.4243

You have the right to a hearing before the Insurance Commissioner, and our action, or the action of the WCIRB, may be affirmed, modified or reversed.

III. Resources Available to You in Obtaining Information and Pursuing Disputes

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1901 Harrison Street, 17th Floor, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159 (phone), 415.371.5288 (fax) and ombudsman@wcirb.com (email).

B. California Department of Insurance - Information and Assistance. Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 800.927.HELP (4357) or insurance.ca.gov. For questions and correspondence regarding appeals to the Administrative Hearing Bureau, see the contact information in paragraph II.C.

This notice does not change the policy to which it is attached.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule.

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

SCHEDULE

Any person or organization for whom you are required by contract or agreement to obtain this waiver from us. Endorsement is not applicable in KY, NH, NJ or for any MO construction risk

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXPERIENCE RATING MODIFICATION FACTOR ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENDING RATE CHANGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

RI

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   New York

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 3.00 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   California
   Connecticut
   Oregon
   District of Columbia
   Oklahoma
   Illinois
   Virginia
   Georgia
   Utah
   New Hampshire
   Colorado
   Kansas
   Maine
   Louisiana

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 2.80 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   Nevada

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 8.70 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   Indiana
   Florida
   Massachusetts
   Arizona
   Iowa
   Rhode Island
   Idaho

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 3.00 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

SCHEDULE

1. State

	Estimated Eligible Premium			
	First	Next	Next	
	$5,000	$95,000	$400,000	Balance
North Carolina		3.5%	5.0%	7.0%

or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 2.80 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   Minnesota
   Pennsylvania

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 2.80 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PREMIUM DISCOUNT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 Item 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. Table of States

   Wisconsin

   or any other State that has approved the premium discount plan applicable to the total policy premium on an interstate basis at the effective date of the policy.

2. Average percentage discount: 5.40 %

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:

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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. 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 manual.

You must report any change in ownership to us in writing within 90 days of such change. Failure to report such changes within this period may result in revision of the experience rating modification factor used to determine your premium.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

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

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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. PLEASE READ IT CAREFULLY.

PREMIUM DUE DATE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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.**

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement is notification that your insurance carrier is charging premium to cover the losses that may occur in the event of a Catastrophe (Other Than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism). This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement (WC 00 04 22 C), attached to this policy.

For purposes of this endorsement, the following definitions apply:

- Catastrophe (Other Than Certified Acts of Terrorism): Any single event, resulting from an Earthquake, Noncertified Act of Terrorism, or Catastrophic Industrial Accident, which results in aggregate workers compensation losses in excess of $50 million.
- Earthquake: The shaking and vibration at the surface of the earth resulting from underground movement along a fault plane or from volcanic activity.
- Noncertified Act of Terrorism: An event that is not certified as an Act of Terrorism by the Secretary of the Treasury pursuant to the Terrorism Risk Insurance Act of 2002 (as amended) but that meets all of the following criteria:
  a. It is an act that is violent or dangerous to human life, property, or infrastructure;
  b. The act results in damage within the United States, or outside of the United States in the case of the premises of United States missions or air carriers or vessels as those terms are defined in the Terrorism Risk Insurance Act of 2002 (as amended); and
  c. It is an act that 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.
- Catastrophic Industrial Accident: A chemical release, large explosion, or small blast that is localized in nature and affects workers in a small perimeter the size of a building.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
See Attached Schedule		

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement is notification that we are charging premium to cover the losses that may occur in the event of a Catastrophe (Other Than Certified Acts of Terrorism) as that term is defined below. Your policy provides coverage for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism). Coverage for such losses is subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations. This premium charge does not provide funding for Certified Acts of Terrorism contemplated under the Terrorism Risk Insurance Program Reauthorization Act Disclosure Endorsement attached to this policy.

For purposes of this endorsement, Catastrophe (Other Than Certified Acts of Terrorism) is defined as: A single event or peril resulting in a group of claims with aggregate workers compensation losses in excess of $50 million. This $50 million threshold applies per occurrence, across all states for which claims arise from a single event or peril.

The premium charge for the coverage your policy provides for workers compensation losses caused by a Catastrophe (Other Than Certified Acts of Terrorism) is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
See Attached Schedule		

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Part Five - Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge. The method for determining the Audit Noncompliance Charge by state, where applicable, is shown in the Schedule below.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part 5 - Premium, E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Schedule

State(s)	Basis of Audit Noncompliance Charge	Maximum Audit Noncompliance Charge Multiplier
AL, AR, CO, CT, DC, DE, GA, IA, ID, IL, KY, MD, ME, MI, MN, MS, NE, NJ, NM, OR, RI, SC, SD, TN, UT, VA, VT, WV	Estimated Annual Premium	Up to two times
AZ, HI, KS, OK	Estimated Annual Premium	Two times
NC	Estimated Annual Premium	Up to three times
NV	Estimated Annual Premium	Up to one times
WI	Estimated Annual Premium	One time

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EXPERIENCE RATING MODIFICATION FACTOR REVISION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement is added to Part Five - Premium of the policy.

The premium for the policy is adjusted by an experience rating modification factor. The factor shown on the Information Page may be revised and applied to the policy in accordance with our manuals and endorsements. We will issue an endorsement to show the revised factor, if different from the factor shown, when it is calculated.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA ALCOHOL- AND DRUG-FREE WORKPLACE PREMIUM CREDIT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

This endorsement provides notice that premium for your policy may be affected by the Arizona Alcohol-and Drug-Free Workplace Premium Credit Program.

You may qualify for a 5% premium credit if you have established and maintain a qualifying alcohol- and drug-free workplace program in accordance with Title 23, Chapter 2, Article 14 of Arizona Statutes.

We will determine your eligibility for this premium credit after total premium has been paid for the policy period and may be revised at the time your final premium audit is processed.

The determination that you have a qualifying program must be made each year that you receive the premium credit. To implement a premium credit program, the following guidelines must be established:

1. Insurers offering the premium credit program may apply a 5% premium credit to qualifying employers.
2. To receive the premium credit, you must:
   a. Provide a written statement to the insurer prior to or within 30 days after the beginning of the policy effective date each year, certifying that the business has implemented a program meeting the requirements of Title 23, Chapter 2, Article 14.
   b. At any time during the term of the policy, provide additional information to the insurer, as required, to confirm that a qualifying program has been established and is being maintained.
   c. Comply with the alcohol and drug testing policy requirements in accordance with Title 23, Chapter 2, Article 14.
   d. Conduct alcohol and drug testing of prospective employees.
   e. Conduct alcohol and drug testing of an employee after the employee has been injured.
   f. Allow us to have access to the alcohol and drug testing results under d. and e. above.
3. The determination that you have established and maintain a qualifying program must be made during each policy term that you receive the premium credit.
4. Your certification and any other information relied upon by the insurer in granting the premium credit must be kept in the insurer's underwriting files and made available to the Department of Insurance upon request.
5. The premium credit may be applied after total premium has been paid for the policy period and may be revised at final audit to the employer's policy. The credit is applicable as a supplement to deviated rates and is applied in a multiplicative manner, after the application of the experience modification, and before the application of the premium discount and expense constant.
6. You must reimburse the premium credit if it is determined that you were not in compliance with the provisions of the program.
7. Minimum premium policies are eligible for this premium credit.
8. Residual market employers are eligible to apply for this premium credit.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Six - Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation and Nonrenewal

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. If you cancel or fail to renew this policy, we must promptly notify the Industrial Commission of Arizona.
3. We may cancel this policy if you fail to pay premium when due, or when one or both of the parties to a professional employer agreement terminate the agreement.
    - If we cancel or nonrenew this policy, we must provide to you and the Industrial Commission of Arizona at least 30 days' notice of the cancellation or nonrenewal.
    - Notice to you may be sent via mail or delivered by electronic means as follows:
        - Mailing that notice to you at your last-known mailing address on file with us will be sufficient proof of notice.
        - Delivery to an email address at which you have consented to receive notices or documents.
        - Posting on a portal, secure website, electronic network or site accessible via the Internet or a mobile application, computer, mobile device, tablet, or other electronic device, together with a separate notice that includes a description of the document or notice that was posted and that was provided by email to the email address at which you consented to receive notice, or by any other delivery method to which you consented.
        - If you consented to have the notice emailed in accordance with Arizona law, emailing that notice to you at your last-known email address as provided by you to us will be sufficient proof of notice.
            - If the email notice is: (1) rejected for delivery; (2) returned to us; or (3) we become aware that the email address provided by you is no longer valid, then we will also mail that notice to you by US Postal Service certified mail, certificate of mailing, or first-class mail using intelligent mail barcode, or another similar tracking method used or approved by the US Postal Service.
            - If we nonrenew this policy and fail to give you notice of nonrenewal, coverage will not extend beyond the policy period.
4. The policy period will end on the date and time stated in the cancellation or nonrenewal notice.
5. Any of these provisions that conflict with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

POLICY AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

1. **Minors Illegally Employed - Not Insured.** This policy does not cover liability for additional compensation imposed on you under Section 4557, Division IV, Labor Code of the State of California, by reason of injury to an employee under sixteen years of age and illegally employed at the time of injury.
2. **Punitive or Exemplary Damages - Uninsurable.** This policy does not cover punitive or exemplary damages where insurance of liability therefor is prohibited by law or contrary to public policy.
3. **Increase in Indemnity Payment - Reimbursement.** You are obligated to reimburse us for the amount of increase in indemnity payments made pursuant to Subdivision (d) of Section 4650 of the California Labor Code, if the late indemnity payment which gives rise to the increase in the amount of payment is due less than seven (7) days after we receive the completed claim form from you. You are obligated to reimburse us for any increase in indemnity payments not covered under this policy and will reimburse us for any increase in indemnity payment not covered under the policy when the aggregate total amount of the reimbursement payments paid in a policy year exceeds one hundred dollars ($100).

   If we notify you in writing, within 30 days of the payment, that you are obligated to reimburse us, we will bill you for the amount of increase in indemnity payment and collect it no later than the final audit. You will have 60 days, following notice of the obligation to reimburse, to appeal the decision of the insurer to the Department of Insurance.
4. **Application of Policy.** Part One, "Workers Compensation Insurance", A, "How This Insurance Applies", is amended to read as follows:

   This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in

Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.

6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.

7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.

8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:

   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:

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

It is further agreed that this policy, including all endorsements forming a part thereof, constitutes the entire contract of insurance. No condition, provision, agreement, or understanding not set forth in this policy or such endorsements shall affect such contract or any rights, duties, or privileges arising therefrom.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT - CALIFORNIA

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

You must maintain payroll records accurately segregating the remuneration of your employees while engaged in the work described in the Schedule.

The additional premium for this endorsement shall be 2 % of the California workers' compensation premium otherwise due on such remuneration.

SCHEDULE

Person or Organization	**Job Description**
Any person or organization for whom you are required by written contract or agreement to obtain this waiver of rights from us	

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Item 2. of the Information Page is replaced by the following:

2. The policy period is from 08/11/22 to 08/11/23 12:01 a.m. in the time zone of the insured's mailing address.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT - CALIFORNIA

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

The insurance afforded by Part Two (Employers' Liability Insurance) by reason of designation of California in Item 3 of the Information Page is subject to the following provisions:

A. "How This Insurance Applies," is amended to read as follows:

A. How This Insurance Applies

This employers' liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury means a physical injury, including 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 California.
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.

C. The **"Exclusions"** section is modified as follows (all other exclusions in the **"Exclusions"** section remain as is):

1. Exclusion 1 is amended to read as follows:
   1. liability assumed under a contract.
2. Exclusion 2 is deleted.
3. Exclusion 7 is amended to read as follows:
   7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.
4. The following exclusions are added:
   1. bodily injury to any member of the flying crew of any aircraft.
   2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.
   3. liability arising from California Labor Code Section 2810.3 which relates to labor contracting.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OPTIONAL PREMIUM INCREASE ENDORSEMENT - CALIFORNIA

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

You must provide us, or our authorized representative, access to records necessary to perform a payroll verification audit. If you fail to provide access within 90 days after expiration of the policy, you are liable to pay a total premium equal to 3 times our current estimate of the annual premium for your policy. In addition, if you fail to provide access after our third request within a 90 day or longer period, you are also liable for our costs in attempting to perform the audit unless you provide a compelling business reason for your failure.

We will contact you to schedule appointments during normal business hours.

We will notify you of your failure to provide access by mailing a certified, return-receipt document stating the increased premium and the total amount of our costs incurred in our attempt(s) to perform an audit. In addition to any other obligations under this contract, 30 days after you receive the notification, you will be obligated to pay the total premium and costs referenced above. If, thereafter, you provide access to your records within three years after the policy expires, or within another mutually agreed upon time, and we succeed in performing the audit to our satisfaction, we will revise your total premium and the costs due to reflect the results of the audit.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

It is agreed that, anything in the policy to the contrary notwithstanding, such insurance as is afforded by this policy by reason of the designation of California in Item 3 of the Information Page is subject to the following provisions:

If you cancel the policy and a disclosure was provided in accordance with Section 481(c) of the California Insurance Code, final premium will be based on the time this policy was in force and increased by the short-rate cancelation table below:

Extended Number of Days	Percent of Full Policy Premium	Extended Number of Days	Percent of Full Policy Premium	Extended Number of Days	Percent of Full Policy Premium
1	5%	95-98	37%	219-223	69%
2	6%	99-102	38%	224-228	70%
3-4	7%	103-105	39%	229-232	71%
5-6	8%	106-109	40%	233-237	72%
7-8	9%	110-113	41%	238-241	73%
9-10	10%	114-116	42%	242-246 (8 mos.)	74%
11-12	11%	117-120	43%	247-250	75%
13-14	12%	121-124 (4 mos.)	44%	251-255	76%
15-16	13%	125-127	45%	256-260	77%
17-18	14%	128-131	46%	261-264	78%
19-20	15%	132-135	47%	265-269	79%
21-22	16%	136-138	48%	270-273 (9 mos.)	80%
23-25	17%	139-142	49%	274-278	81%
26-29	18%	143-146	50%	279-282	82%
30-32 (1 mo.)	19%	147-149	51%	283-287	83%
33-36	20%	150-153 (5 mos.)	52%	288-291	84%
37-40	21%	154-156	53%	292-296	85%
41-43	22%	157-160	54%	297-301	86%
44-47	23%	161-164	55%	302-305 (10 mos.)	87%
48-51	24%	165-167	56%	306-310	88%
52-54	25%	168-171	57%	311-314	89%
55-58	26%	172-175	58%	315-319	90%
59-62 (2 mos.)	27%	176-178	59%	320-323	91%
63-65	28%	179-182 (6 mos.)	60%	324-328	92%
66-69	29%	183-187	61%	329-332	93%
70-73	30%	188-191	62%	333-337 (11 mos.)	94%
74-76	31%	192-196	63%	338-342	95%
77-80	32%	197-200	64%	343-346	96%
81-83	33%	201-205	65%	347-351	97%
84-87	34%	206-209	66%	352-355	98%
88-91 (3 mos.)	35%	210-214 (7 mos.)	67%	356-360	99%
92-94	36%	215-218	68%	361-365 (12 mos.)	100%

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA CANCELATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of California Insurer: Property and Casualty Insurance Company of Hartford

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

The cancelation condition in Part Six (Conditions) of the policy is replaced by these conditions:

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 for one or more of the following reasons:
   a. Non-payment of premium;
   b. Failure to report payroll;
   c. Failure to permit us to audit payroll as required by the terms of this policy or of a previous policy issued by us;
   d. Failure to pay any additional premium resulting from an audit of payroll required by the terms of this policy or any previous policy issued by us;
   e. Material misrepresentation made by you or your agent;
   f. Failure to cooperate with us in the investigation of a claim;
   g. Material failure to comply with federal or state safety orders or written recommendations of our designated loss control representatives;
   h. The occurrence of a material change in the ownership of your business;
   i. The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
   j. The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
   k. The occurrence of any change in your business or operation which contemplates an activity excluded by our reinsurance treaties.
3. If we cancel your policy for any of the reasons listed in (a) through (f), we will give you 10 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. If we cancel your policy for any of the reasons listed in Items (g) through (k), we will give you 30 days advance written notice; however, we agree that in the event of cancelation and reissuance of a policy effective upon a material change in ownership or operations, notice will not be provided.
4. If we mail the notice to you, the stated periods of notice and your right to remedy the condition will be extended by 5 days if the place of mailing and your mailing address is within California, 10 days if the place of mailing or your mailing address is outside of California and 20 days if the place of mailing or your mailing address is outside of the United States.
5. The policy period will end on the day and hour stated in the cancelation notice.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COLORADO CLASSIFICATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Colorado is shown in Item 3.A. of the Information Page.

Section B. Classifications of Part Five (Premium) is amended by adding the following:

The assignment of a proper classification resulting in higher premium is allowed only if the misclassification was caused by your failure to provide accurate or complete data. If your operation changes during the policy term, you must notify us within ninety days of the change. Failure to notify us will be considered a failure to provide accurate or complete data.

Section E. Final Premium of Part Five is amended by adding this sentence at the end of the first paragraph:

Payments to us or to you based on improper classification may be collected or refunded during the term of the policy and for twelve months after the term.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COLORADO PREMIUM CREDIT FOR CERTIFIED RISK MANAGEMENT PROGRAMS ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies to Part One (Workers Compensation Insurance) because Colorado is listed in Item 3.A of the Information Page.

The Colorado Workers Compensation Cost Containment Board has determined that a premium differential shall be provided on all policies when you have selected a designed medical provider.

If you qualify for experience and/or schedule rating and you have implemented a certified workers compensation risk management program or service, we must allow a 5% premium credit if your loss experience has improved since your last renewal date. The Schedule below will indicate if you qualify for this credit.

If you do not qualify for experience and/or schedule rating on your workers compensation insurance and you have implemented a certified workers compensation risk management program or service, we must offer premium credits as follows:

Premium Credit	Credit Criteria
10%	If you have been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If you have had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If you have had two medical losses, each exceeding $250 within the last year immediately preceding the effective date of the premium credit.
4%	If you have had three medical losses, each exceeding $250 within the last year immediately preceding the effective date of the premium credit.
2%	If you have had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If you have had more than three medical losses and one claim for loss time in the last year immediately preceding the effective date of the premium credit.

Countersigned by _____
Authorized Representative

If you have selected a designated medical provider, we must allow a credit 0f 2.5%. If you are eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation.

If you are not eligible for experience or schedule rating, the 2.5% credit will be applied, in addition to the premium credit applicable. The combined premium credit and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%

Schedule

% Premium Credit	**Certified Risk Management Program/Designated Medical Provider**

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT APPLICATION OF WORKERS COMPENSATION INSURANCE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

Section A, 'How This Insurance Applies' of Part One, 'Workers Compensation Insurance,' is amended to read as follows:

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

(1) Injury by accident must occur during the policy period.

(2) Injury by disease must be caused or aggravated by exposure during the policy period to conditions of your employment.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part One (Workers' Compensation Insurance) because Connecticut is shown in Item 3.A. of the Information Page.

The amount shown on the Information Page for the Connecticut workers compensation fund assessment is required of you under Section 31-345 of the Connecticut General Statutes. We will pay these assessments to the Connecticut State Treasurer.

The purpose of the assessment is to finance the expenses of administering the workers compensation laws.

THE AMOUNT SHOWN ON THE INFORMATION PAGE FOR THE CONNECTICUT SECOND INJURY FUND SURCHARGE IS REQUIRED OF YOU UNDER CONNECTICUT REGULATIONS TO FINANCE THE CONNECTICUT SECOND INJURY FUND. WE WILL PAY THIS SURCHARGE TO THE CONNECTICUT STATE TREASURER.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CONNECTICUT NONRENEWAL AND RENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

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

F. Nonrenewal

We may elect not to renew the policy. Unless otherwise provided by Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intention not to renew. Advance notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

Mailing such notice to you at your address, shown in Item 1. of the Information Page, will be deemed sufficient notice under this section.

The notice of intent not to renew will state or be accompanied by a statement specifying the reason for such nonrenewal.

G. Renewal

We may elect to renew the policy. In accordance with Connecticut General Statutes Annotated Section 38a-323, we will provide you at least 60 days' advance notice of our intent to renew if, compared to this policy, the terms or conditions of the renewal policy include any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles.

This conditional renewal notice will be provided to you by one of the following methods:

1. Registered mail
2. Certified mail
3. Mail evidenced by a certificate of mailing
4. Delivered to the named insured at the address shown in the policy

Mailing such notice to you at your address, shown in Item 1., of the Information Page, will be deemed sufficient notice under this section.

This conditional renewal notice will include or be accompanied by a statement clearly identifying any reduction in coverage limits, coverage provisions added or revised that reduce coverage or increases in deductibles, under the renewal policy.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

DISTRICT OF COLUMBIA
CANCELLATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by this Condition.

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail or deliver to you and the Mayor not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing this notice to you at your mailing address last known to us will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

This insurance does not cover

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

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

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

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.

2. We document the audit file regarding the above attempts to obtain the required audit information.

3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

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

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA INSUFFICIENT FUNDS ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

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

G. Insufficient Funds

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

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

Schedule

Insufficient Funds Fee	$15

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

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

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

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

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

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

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

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

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

Schedule

Surcharge rate 0.0 %

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GEORGIA CANCELLATION, NONRENEWAL, AND CHANGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Six - Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation, Nonrenewal, and Change

1. You may cancel this policy. You must mail or deliver advance notice to us in writing, or deliver advance notice orally or electronically, stating when the cancellation is to take effect. We may require that you provide written, electronic, or other recorded verification of the request before the cancellation takes effect. The cancellation is subject to the following:
   a. If only your interest is affected, the effective date of cancellation will be the later of the date we receive notice from you or the date specified in the notice.
   b. If by statute, regulation, or contract this policy may not be cancelled unless notice is given to a governmental agency or other third party, we will mail or deliver at least 10 days' notice to you and the third party as soon as practical after receiving your request for cancellation.

      Our notice will state the effective date of cancellation, which will be the later of the following:
      1) 10 days from the date of mailing or delivering our notice, or
      2) The effective date of cancellation stated in your notice to us.
2. We may cancel or nonrenew this policy. We must mail or deliver notice at least 10 days before the effective date of cancellation if this policy has been in effect less than 60 days or if we cancel for nonpayment of premium. If this policy has been in effect 60 or more days and we cancel for a reason other than nonpayment of premium, or if we nonrenew this policy, we must send a notice of cancellation or nonrenewal by certified mail, return receipt requested, to you at your last address of record at least 75 days before the effective date of cancellation or nonrenewal.
3. If we increase current policy premium by more than 15% (other than any increase in premium due to change in risk or exposure, including a change in experience rating modification or resulting from an audit of auditable coverages), we must deliver a notice of our action (including dollar amount of the increase in renewal premium more than 15%) to you, by first class mail, at your last address of record at least 45 days before the expiration date of this policy.
4. If we reduce the policy coverage, we must provide you with written notice at least 45 days before the effective date of the reduction in coverage. The notice will be delivered to you in person or by first class mail to your last address of record. A reduction in coverage made by us includes elimination of coverage, a decrease in scope or less coverage, or the addition of an exclusion. Requests made by you to change, reduce, or eliminate coverage are not considered reductions in coverage.
5. If you fail to submit to, or allow an audit for, the current or most recently expired policy term, we may, after two documented efforts to notify

you and your agent of potential cancellation, send via certified mail or statutory overnight delivery, return receipt requested, written notice to you at least 10 days before the effective date of cancellation in lieu of the number of days' notice otherwise required by state law. However, we must not mail a cancellation notice within 20 days of the first documented effort to notify you of potential cancellation.

6. The policy period will end on the day and hour stated in the cancellation notice except as provided for above.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ILLINOIS WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY EXCLUSION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

C. Change Part Two – C. Exclusions 1. as follows:

This insurance does not cover

1. liability assumed under a contract, and/or any agreement to waive your right to limit your liability for contribution to the amount of benefits payable under the Workers Compensation Act and the Workers Occupational Disease Act. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ILLINOIS AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Two - Employers Liability Insurance, Section B. (We Will Pay), Item 3. of the policy is replaced by the following:

3. For consequential bodily injury to a party to a civil union, 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

Part Five - Premium, Section G. (Audit) of the policy is replaced by the following:

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 ends. Information developed by audit will be used to determine final premium. The National Council on Compensation Insurance has the same rights we have under this provision.

Part Six - Conditions, Section A. (Inspection) of the policy is replaced by the following:

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. The National Council on Compensation Insurance has the same rights we have under this provision.

Part Six - Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancellation is to take effect.
2. We may cancel this policy. We will mail to each named insured at the last known mailing address advance written notice stating when the cancellation is to take effect. We will maintain proof of mailing of the notice of cancellation. A copy of all such notices shall be sent to the broker or agent of record, if known, at the last known mailing address. The broker or agent of record may opt to accept notification electronically.

3. If we cancel because you do not pay all premium when due, we will mail the notice of cancellation at least ten days before the cancellation is to take effect. If we cancel for any other reason, we will mail the notice:
   a. At least 30 days before the cancellation is to take effect if the policy has been in force for 60 days or less;
   b. At least 60 days before the cancellation is to take effect if the policy has been in force for 61 days or more.
4. If this policy has been in effect for 60 days or more, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. The policy was issued because of a material misrepresentation;
   c. You violated any of the terms and conditions of the policy;
   d. The risk originally accepted has measurably increased;
   e. The Director has determined that we no longer have adequate reinsurance to meet our needs; or
   f. The Director has determined that continuation of coverage could place us in violation of the laws of Illinois.
5. Our notice of cancellation will state our reasons for cancelling.
6. The policy period will end on the day and hour stated in the cancellation notice.

Part Six - Conditions, Section E. (Sole Representative) of the policy is replaced by the following:

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, or give us notice of cancellation.

Part Six - Conditions of the policy is changed by adding the following:

F. Nonrenewal

1. We may elect not to renew the policy. We will mail to each named insured the nonrenewal notice at the last known mailing address at least 60 days prior to the expiration of the current policy. We will maintain proof of mailing of the nonrenewal notice. An exact and unaltered copy of such notice will also be sent to the named insured's producer, if known, or the producer of record at the last known mailing address. The named insured's producer, if known, or the producer of record may opt to accept notification electronically.
2. If we fail to give at least 60 days' notice prior to the expiration date of the current policy, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this policy. Additionally, in accordance with 215 ILCS 5/462a, we may be required to provide the named insured with 30 days' written notice prior to the expiration of this policy if the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.
3. Our notice of nonrenewal will provide a specific explanation on the reasons for not renewing.
4. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. You notify us or the producer who procured this policy that you do not want the policy renewed; or
   b. You fail to pay all premiums when due; or
   c. You obtain other insurance as a replacement of the policy.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ILLINOIS RENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

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

G. Renewal

1. We may elect to renew the policy in accordance with 215 ILCS 5/143.17a.
   a. We will provide the named insured with written notice of our intent to renew if, compared to this current policy, the:
      - Renewal policy premium increases by 30% or more, or
      - Changes in deductibles or coverage materially alter the renewal policy.
   b. We will mail or deliver the written renewal notice:
      - To the named insured at the last known mailing address
      - At least 60 days prior to the renewal or anniversary date of this current policy.
   c. If we fail to provide notice 60 days prior to the renewal or anniversary date, but we do mail or deliver the written renewal notice to the named insured not less than 31 days prior to the renewal or anniversary date of this current policy, then we may extend this policy at the current terms and conditions for the period of time needed to equal the 60 day time period required to provide notice of intention to renew.
   d. All renewal notices will also be sent to the producer, if known, or the producer of record, and to the mortgagee or lien holder listed on the policy. The producer, if known, or the producer of record and the mortgagee or lien holder may opt to accept notification electronically.
   e. If we fail to provide renewal notice as required above, the policy will automatically be extended for one year under the same terms and conditions. We may increase the renewal premium, but such increase must be less than 30% of this policy's premium and notice of such increase must be delivered to the named insured on or before the date of expiration of this current policy. The increase in premium is based on the known exposure as of the date of the quotation compared to the premium as of the last day of coverage for the current year's policy, annualized. The renewal premium may be subsequently amended to reflect any change in exposure or reinsurance costs not considered in the quotation.
   f. If we fail to provide the notice of renewal as required, the policy will still terminate on its expiration date if:
      (1) You notify us or the producer who procured this policy that you do not want the policy renewed; or
      (2) You fail to pay all premiums when due; or
      (3) You obtain other insurance as a replacement of the policy.
   g. Proof of mailing or proof of receipt of the notice of intent to renew to the named insured may be proven by a sworn affidavit by the company as to the usual and customary business practices of mailing notice pursuant to 215 ILCS 5/143.17a or may be proven consistent with Illinois Supreme Court Rule 236.

2. We may elect to conditionally renew the policy in accordance with 215 ILCS 5/462a.
   a. For policies issued, delivered, amended, or renewed on or after January 1, 2019 (“this policy”) we will provide the employer with written notice of our intent to conditionally renew if, compared to this policy, the renewal premium is in excess of 5% above the rate recommendation filed with and approved by the Illinois Department of Insurance.
   b. To determine whether the renewal premium is in excess of 5% above the rate recommendation, we will **not** consider any premium increases generated from the following items:
      - Increased loss costs
      - Increased exposure units
      - The application of an experience rating modification
      - The application of a contracting classification premium adjustment program
      - The application of a large deductible program
      - The application of a retrospective rating plan
      - An audit of auditable coverages
   c. Mailing or delivering such written notice to the employer at least 30 days in advance of the expiration date of this policy, at the address shown in Item 1. of the Information Page, and to the authorized agent or broker will be deemed sufficient notice under this section.
   d. This conditional renewal notice will include a statement that clearly identifies:
      (1) The amount of the premium increase or, if the amount cannot reasonably be determined as of the time the notice is provided, a reasonable estimate of the premium increase based on information available to us at that time
      (2) The reason for the increased premium in excess of the rate recommendation filed with the Illinois Department of Insurance

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KANSAS FINAL PREMIUM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement changes how the final premium is determined. The change applies only to the premium charged because Kansas is shown in Item 3.A. of the Information Page.

- Kansas final premium will not be less than the highest minimum premium for the classifications covered by this policy unless there are two or more classifications covered and the highest rated classification has less than $500 payroll.
- When this occurs the final premium will not be less than one-half of the sum of the two highest minimum premiums for any classifications covered by the policy other than Clerical Office and Salespersons.
- When the highest rated classification has less than $500 payroll and Standard Exception classifications are the only classifications showing payrolls, the final premium will not be less than the minimum premium for the classification showing the highest payroll.
- Final premium for a multiple state policy will be that of the state with the single highest minimum premium, even if that state is on an "if any" basis. If two or more states have the same highest minimum premium, the minimum premium is determined by the state with the largest amount of standard premium.
- Minimum premium is subject to final adjustment at audit and will be determined only on the basis of the classifications developing premium.
- If the final earned premium is less than the minimum premium determined at audit, then that minimum premium must be charged.
- If no classification develops premium, the final premium shall be a flat charge of $200.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KANSAS PENDING LOSS COST ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The premium for this policy is determined by the product of loss costs developed and filed by the National Council on Compensation Insurance, Inc. and a loss cost multiplier filed by us. The loss costs and our loss cost multiplier are subject to approval by the Kansas Insurance Department. Revised loss costs developed by the National Council on Compensation Insurance, Inc. are currently pending before the Kansas Insurance Department. The Kansas Insurance Department's decision on the change may increase or decrease the premium from that used to issue your policy. If it is different, your policy will be endorsed to reflect the new premium based on the loss costs approved by the Kansas Insurance Department.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

KANSAS CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by these two Conditions:

Cancellation

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. If we cancel because you fail to pay all premium when due, we will mail or deliver to you not less than 10 days advance written notice stating when the cancellation is to take effect. If we cancel for any other reason, we will mail or deliver to you not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.
3. If this policy has been in effect for 90 days or more, we may cancel only for one of the following reasons:
   a. nonpayment of premium;
   b. the policy was issued because of a material misrepresentation;
   c. you violated any of the material terms and conditions of the policy;
   d. there are unfavorable underwriting factors, specific to you, that were not present when the policy took effect;
   e. the Commissioner has determined that our continuation of coverage could place us in a hazardous financial condition or in violation of the laws of Kansas; or
   f. the Commissioner has determined that we no longer have adequate reinsurance to meet our needs.
4. Our notice of cancellation will state our reasons for canceling.
5. The policy period will end on the day and hour stated in the cancellation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice when the nonrenewal will 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.
2. Our notice of nonrenewal will state our reasons for not renewing.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

LOUISIANA DUTY TO DEFEND ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The duty to defend provision of the policy is replaced by this provision.

Part Two - Employers' Liability

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. Our duty to defend ends when the limit of liability has been exhausted by the payment of a judgement or settlement.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

LOUISIANA AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Two - Employers Liability Insurance, Section 1. (Actions Against Us) of the policy is replaced by the following:

I. Actions Against Us

You may not bring an 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 judgement.

The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

Part Five - Premium, Section E. (Final Premium) of the policy is replaced by the following:

E. Final Premium

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

If this policy is cancelled, 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 that 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 calculated using one of the following methods as listed in the Schedule of this endorsement:
   a. Pro rata based on the time that this policy was in force. Final premium will not be less than the pro rata share of the minimum premium, or
   b. More than pro rata; it will be based on the time that this policy was in force, and increased by our short-rate cancellation procedure that has been filed with and approved by the commissioner. Final premium will not be less than the minimum premium.

Part Five - Premium, Section G. (Audit) of the policy is revised by adding the following:

G. Audit

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge equal to a maximum of up to two times the estimated annual premium. The method for determining the Audit Noncompliance Charge, and the maximum dollar amount, is shown in the Schedule of this endorsement.

If you allow us to examine and audit all of your records after we have applied an Audit Noncompliance Charge, we will revise your premium in accordance with our manuals and Part Five - Premium, Section E. (Final Premium) of this policy.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Part Six - Conditions, Section D. (Cancellation) of the policy is replaced by the following:

D. Cancellation

For Home and Community-Based Services (HCBS) providers, refer to Section G. in lieu of Section D. for cancellation provisions.

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you at the mailing address shown on the policy or your last address of record at least 60 days before the cancellation effective date, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered at least 10 days before the effective date of cancellation. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:
   a. Nonpayment of premium
   b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Activities or omissions on your part that change or increase any hazard insured against, including a failure to comply with loss control recommendations
   d. Change in the risk that increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
   e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
   f. Violation or breach by the insured of any policy terms or conditions
   g. Such other reasons that are approved by the commissioner of insurance
2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions 1.b. through 1.g. of Section D-1 will be mailed or delivered at least 30 days before the effective date of the cancellation; notices of cancellations based on condition 1.a. of Section D-1 will be mailed or delivered at least 10 days before the effective date of cancellation. The notice will state the effective date of the cancellation.
   b. We will provide you with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:
      (1) Giving notice of or specifying the reasons for a cancellation, or
      (2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement.
3. We will provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.
4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or your last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss-run information for the period the policy has been in force within, but not to exceed the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the policy expiration date will be considered pro rata based on the previous year's rate. For purposes of this endorsement, the transfer of a policyholder

between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.

5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.
6. If we provide the notice described in paragraph 4 above and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.
7. We must mail or deliver to you at the mailing address shown on the policy or your last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage at least 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy's rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first. For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice. If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any, and other changes will be effective the day following the prior policy's expiration date.
8. Paragraph 7 does not apply to changes:
   a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business
   b. Based on the altered nature or extent of the risk insured
   c. In policy forms filed and approved with the commissioner and applicable to an entire class of business
   d. Requested by the insured
9. Proof of mailing or delivery of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the mailing address shown in the policy or the last address of record, will be sufficient proof of notice.

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

F. Your Right to Remove Agent

We will not change or remove the agent of record who wrote this policy before the termination or renewal of this policy unless you request the change or removal. If you request the change or removal of the agent, we will notify the agent in writing 10 calendar days before the change or removal.

Schedule

1. If you cancel, final premium for this policy will be calculated: X pro rata, or _____ more than pro rata

2. **Basis of Audit**
   Noncompliance Charge Estimated Annual Premium

   Maximum Audit Noncompliance Charge Multiplier Two times

   Maximum Audit Noncompliance Charge $ Amount 1656

Part Six—Conditions, Section D. (Cancellation) of the policy is replaced for Home and Community-Based Services (HCBS) providers by adding Part Six—Conditions, Section G. The following cancellation provisions are to be used when the policy provides coverage to an HCBS provider and are intended to comply with Chapter 50 of the Louisiana Administrative Code, Title 48, Part I, Sections 5007, 5014, and 5015:

G. Cancellation—Home and Community-Based Services (HCBS) Providers

1. If coverage has not been in effect for 60 days and the policy is not a renewal, cancellation will be effected by mailing or delivering a written or electronic (in accordance with the Louisiana Uniform Electronic Transactions Act) notice to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record 60 days before any cancellation or change of coverage, except in cases where cancellation is based on nonpayment of premium. Notice of cancellation based on nonpayment of premium will be mailed or delivered 30 days before the effective date of cancellation. After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, we will not cancel the policy unless the cancellation is based on at least one of the following reasons:
   a. Nonpayment of premium
   b. Fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or in presenting a claim under the policy
   c. Activities or omissions on your part that change or increase any hazard insured against, including a failure to company with loss control recommendations
   d. Change in the risk that increases the risk of loss after insurance coverage has been issued or renewed, including an increase in exposure due to regulation, legislation, or court decision
   e. Determination by the commissioner of insurance that continuing the policy would jeopardize your solvency or would place us in violation of the insurance laws of this state or any other state
   f. Violation or breach by the insured of any policy terms or conditions
   g. Such other reasons that are approved by the commissioner of insurance
2. The insurer is required to provide notification of cancellation as follows:
   a. A notice of cancellation of insurance coverage by us will be in writing or by electronic means and will be mailed or delivered to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or your last address of record. Notices of cancellation based on conditions 1.a. through 1.g. of Section G-1 will be mailed or delivered 30 days before the effective date of the cancellation. The notice will state the effective date of the cancellation.
   b. we will provide you and the certificate holder 9LDH Health Standards Section) with a written or electronic statement specifying the reason for the cancellation when you request such a statement in writing. Your written or electronic request must state that you hold us harmless from liability for any communication:
      (1) Giving notice of or specifying the reasons for a cancellation or
      (2) For any statement made in connection with an attempt to discover or verify the existence of conditions that would be a reason for cancellation under this endorsement
3. We will provide a notice of cancellation or a statement of reasons for cancellation to you and the certificate holder (LDH Health Standards Section) where cancellation for nonpayment of premium is effected by a premium finance company or other entity pursuant to a power of attorney or other agreement executed by or on behalf of you.
4. We may decide not to renew your policy. If we decide not to renew your policy, we will mail or deliver written or electronic notice to you at the mailing address shown on the policy or your last address of record. Such notice of nonrenewal will be mailed or delivered at least 60 days before the policy expiration date. Such notice to you will include your loss-run information for the period the policy has been in force within, but

not to exceed, the last three years of coverage. If the notice is mailed or delivered less than 60 days before expiration, coverage will remain in effect under the same terms and conditions until 60 days after the notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the policy expiration date will be considered pro rata based on the previous year's rate. For purposes of the endorsement, the transfer of a policyholder between companies within the same insurance group will not be a refusal to renew. In addition, changes in the deductible, changes in rate, changes in the amount of insurance, or reductions in policy limits or coverage will not be refusals to renew.

5. Notice of nonrenewal will not be required if we or a company within the same insurance group has offered to issue a renewal policy, or where you have obtained replacement coverage or have agreed in writing to obtain replacement coverage.
6. If we provide the notice described in paragraph 4 above, and thereafter we extend the policy for 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.
7. We must mail or deliver to you and the certificate holder (LDH Health Standards Section) at the mailing address shown on the policy or the last address of record, written or electronic notice of any rate increase, change in deductible, or reduction in limits or coverage 30 days before the expiration date of the policy. If we fail to provide such 30-day notice, the coverage provided to you at the expiring policy's rate, terms, and conditions will remain in effect until notice is given or until the effective date of replacement coverage obtained by you, whichever occurs first. For the purposes of this paragraph, notice is considered given 30 days following the date of mailing or delivery of the notice. If you elect not to renew, any earned premium for the period of extension of the terminated policy will be calculated pro rata at the lower of the current or previous year's rate. If you accept the renewal, the premium increase, if any,

   and other changes will be effective the day following the prior policy's expiration date.
8. Paragraph 7 does not apply to changes:
   a. In a rate or plan filed with the commissioner of insurance and applicable to an entire class of business
   b. Based on the altered nature or extent of the risk insured
   c. In policy forms filed and approved with the commissioner and applicable to an entire class of business
   d. Requested by the insured
9. Proof of mailing or delivery of notice of cancellation, or of nonrenewal, or of premium or coverage changes to the named insured and the certificate holder (LDH Health Standards Section) where applicable at the mailing address shown in the policy or at the last address of record, will be sufficient proof of notice.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

LOUISIANA COST CONTAINMENT ACT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

You may be eligible for a two (2) percent reduction in your premium if you attend a cost containment meeting conducted by the Occupational, Safety and Health Administration (OSHA) Section of the Office of Workers Compensation Administration. In order for you to receive the reduction, you must submit to us a certificate of attendance from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date you attended the cost containment meeting.

You may also be eligible for an additional five (5) percent reduction in your premium if you have attended a cost containment meeting and have subsequently satisfactorily implemented an occupational safety and health program prescribed by the OSHA Section. In order for you to receive the reduction, you must submit to us a Certificate of Satisfactory Implementation of Occupational, Safety and Health Program from the OSHA Section. The reduction will apply for a period of one year and will be applied to the policy becoming effective after the date of your certification.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE MERIT RATING ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement is attached, incorporated into, and applies to your policy because Maine is shown in Item 3.A. of the Information Page.

The premium for this insurance is subject to merit rating because your premium is less than the amount necessary to be eligible for experience rating.

The following credits or debits will be applied to your manual premium based on your lost-time claims made during the most recent three-year period for which statistics are available:

1. An 8% credit will be applied if you had no claims or had a loss ratio of less than 1.0;
2. No credit or debit will be applied if you had one claim resulting in a loss ratio greater than 1.0;
3. An 8% debit will be applied if you had two or more claims resulting in a loss ratio greater than 1.0.

Loss ratio is the ratio of actual incurred losses during the previous three-year period to the actual earned premiums during that period. We will use the same three-year period used in experience rating to calculate your loss ratio.

The following claims are excluded from this merit rating plan:

- Claims identified as an aggravation of a prior lost-time work-related injury, in accordance with Maine Rule 450 requirements
- Claims attributable to the COVID-19 (coronavirus) pandemic

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE INSPECTION IMMUNITY ENDORSEMENT (TITLE 14 MAINE REVISED STATUTES ANNOTATED SECTION 167)

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

THE FOLLOWING LIMITS OUR LIABILITY

We, the insurance company, our agents, employees, or service contractors, are not liable for damages from injury, death or loss occurring as a result of any act or omission in the furnishing of or the failure to furnish insurance inspection services related to, in connection with or incidental to the issuance or renewal of a policy of property or casualty insurance.

This exemption from liability does not apply:

A. If the injury, loss or death occurred during the actual performance of inspection services and was proximately caused by our negligence or by the negligence of our agents, employees or service contractors;

B. To any inspection services required to be performed under the provisions of a written service contract or defined loss prevention program;

C. In any action against us, our agents, employees, or service contractors for damages proximately caused by our acts or omissions which are determined to constitute a crime, actual malice or gross negligence; or

D. If we fail to provide this written notice to the insured whenever a policy is issued or when new policy forms are issued upon renewal.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by this Condition:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you and to the Workers Compensation Board not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice. If you have obtained a workers compensation and employers liability insurance policy from another insurance company or have otherwise secured your obligation to provide compensation, and such insurance or other security becomes effective prior to the expiration of the notice period, the policy period will end on the effective date of such other insurance or security.
4. If this policy has been renewed or has been in effect for 60 days or more, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. Fraud or a material misrepresentation was made in obtaining the policy, continuing the policy or presenting a claim under the policy;
   c. The risk accepted when the policy has issued substantially increased;
   d. Your failure to comply with reasonable loss control recommendations;
   e. A substantial breach of contractual duties, conditions or warranties under the policy;
   f. The Superintendent has determined that continuation of the policy could jeopardize our solvency or place us in violation of the law.

Nonrenewal

We may elect not to renew the policy. We will mail or deliver to you not less than 30 days advance written notice. A post office certificate of mailing to you at your last known address will be conclusive proof of receipt of that notice on the third calendar day after mailing.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE FINAL PREMIUM AUDIT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Five (Premium), Condition E, **Final Premium**, and Condition G, **Audit**, are changed by adding these Conditions:

E. Final Premium

We are required by Maine regulation to complete our final premium audit not later than 120 days after the policy period ends.

If we are unable to examine and audit your records because of your failure to cooperate, we will mail advance written notice to you stating the reasons for our inability to establish the final premium. Your final premium will be established no later than 120 days from the time we are able to complete the examination and audit of your records.

If we have not established the final premium within the 120-day time limitation, we may not bill or collect any additional premium that exceeds the latest billed annual premium.

G. Audit

You may request a final premium audit to determine whether you are entitled to a refund, if we have not established the final premium within the 120-day time limit. You will mail or deliver written notice to us requesting the audit.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE NOTICE OF FILING OF FIRST REPORTS OF INJURY WITHIN SEVEN DAYS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Employer's First Report of Occupational Injury or Disease, form WCB-1, required to be filed for injuries arising out of and in the course of an employee's employment that has caused the employee to lose a day's work shall be reported to and received by the Workers' Compensation Board within SEVEN days after the employer receives notice or knowledge of the injury, as provided by 39-A M.R.S.A. sec. 303. First Reports of Injury can be mailed, electronically submitted or faxed to the Workers' Compensation Board at 207-287-5895.

Contact us immediately if an injury occurs which may be required to be reported to the Workers' Compensation Board.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MAINE SUPPLEMENTAL BENEFITS FUND ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Title 39-A of Maine Revised Statute Annotated, sections 355A through section 356 establishes the Maine Supplemental Benefits Fund to reimburse insurers and self-insurers for their payments of compensation to employees made pursuant to 39-A M.R.S.A. § 213(3),(4).

We are authorized pursuant to 39-A M.R.S.A. § 356 to collect a surcharge from you to pay the assessments required pursuant to 39-A M.R.S.A. § 154(3). Your surcharge will be calculated in accordance with 39-A M.R.S.A. § 154(3)(B-1).

Schedule

Surcharge: %

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because Massachusetts is listed in Item 3.A. of the Information Page.

Our liability to you under Section 25 of Chapter 152 of the General Laws of Massachusetts is not subject to the limit of liability that applies to Part Two (Employers Liability Insurance).

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

1. Rates and Premium
   The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact your agent or us.

   You may obtain pertinent rating information by submitting a written request to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this endorsement or to us at our company address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

   You may also submit a written request for a review of the method by which your classification, rates, premiums or audit results were determined. If we fail to grant or reject your request within thirty days after it is made or if you are not satisfied by the results of our review, you may submit a written request for review to the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") at the address shown in this endorsement. If the WCRIBMA fails to grant or reject your request within thirty days after it is made or [i]f you are not satisfied with the results of the WCRIBMA review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Reserve or Settlements

   You may request a loss run, which contains reserve and settlement information for claims that relate to the premium for this policy. Such a request must be in writing and should be sent to our address shown on this endorsement. We will provide you with that information within thirty (30) days of receipt of your request, and at reasonable intervals thereafter.

   If you have any questions or believe that we set unreasonable reserves or made unreasonable settlements that affected your premiums or losses, you may make a written request through your agent or directly to us for a meeting with our company representative. If you are not satisfied with the results of the meeting, you may make a written appeal to the Insurance Commissioner at the address shown on the endorsement.

3. Named Insured
   You are responsible for immediately reporting all changes in name or legal status to us in writing at the company address shown in this Endorsement.

   If you want to add a named insured or replace the named insured with another legal entity on any policy issued through the Massachusetts Assigned Risk Pool you must submit a new Assigned Risk Pool Application, including a Confidential Request for Information Form (ERM), to the Workers'

Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this Endorsement

4. Insured's Mailing Address
Notices relating to this Policy will be mailed or delivered to your mailing address. Your mailing address is that which is shown in Item 1 of the Information Page or in a change of address Endorsement to the Policy. You are responsible for notifying us in writing at the company address shown in this Endorsement about any change to your mailing address.

Addresses

The Workers' Compensation Rating and
Inspection Bureau of Massachusetts
Attention: Customer Service Department
101 Arch Street, 5th Floor
Boston, MA 02110
www.wcribma.org

Company Address
Twin City Fire Insurance Company
3600 WISEMAN BLVD
SAN ANTONIO TX 78251

Commissioner of Insurance
Division of Insurance
Department of Banking and Insurance
1000 Washington St 8th Floor
Boston, MA 02118-2218

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS PENDING PREMIUM CHANGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

A filing is being considered by the Massachusetts Division of Insurance which may result in premiums different from those shown on the policy. If it does, we will issue an endorsement to show the new premiums and their effective date.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

PART FIVE
PREMIUM

D. Premium Payments 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 is not valid. **The audit and retrospective premiums shall be paid by the due date indicated on the billing statement.**

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MASSACHUSETTS CANCELLATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by the following:

Cancellation

1. You may cancel this policy by mailing or delivering to us advance written notice requesting cancellation. Such cancellation shall not be effective until ten days after written notice is given by us to The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

2. We may cancel this policy only if based on one or more of the following reasons: (i) nonpayment of premium; (ii) fraud or material misrepresentation affecting your policy; or (iii) a substantial increase in the hazard insured against. Such cancellation shall not be effective until ten days after written notice is given by us to you and the Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

3. We will mail or deliver the notice of cancellation to you at your last address, which shall be the mailing address shown in Item 1 of the Information Page or the change of mailing address shown in an Endorsement to the Policy. Pursuant to M.G.L. Chapter 175, Section 187C, a written notice of cancellation shall be deemed effective when mailed by us if we obtain a certificate of mailing receipt from the United States Postal Service showing your name and address as stated in the policy.

4. Any of these provisions that conflict with the law that controls the cancellation of this insurance policy is changed by this statement to comply with the law.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MINNESOTA AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

PART TWO - EMPLOYERS LIABILITY INSURANCE

E. We will Also Pay is amended to read:

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. your share of pre-or postjudgment interest assuming that the principal amount of that judgment is within the applicable policy limits under this insurance; and
5. expenses we incur.

H. Recovery From Others is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for an injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

PART FIVE - PREMIUM

G. Audit is amended to read:

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, except as it pertains to Part Two - Employers' Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

DEFINITIONS

As used in this policy " rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Cancellation of a New Policy

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of cancellation.

Cancellation of Other Policies

If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

Notice of Cancellation

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or delivered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.

Refunds Due You

If this policy is cancelled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

1. Insured elsewhere;
2. Accepted replacement coverage; or
3. Requested or agreed not to renew this policy.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Six – Conditions, D. Cancellation of the policy is replaced by the following:

A. Midterm Cancellation

1. You may cancel this policy by mailing or delivering advance written notice to us stating when the cancellation is to take effect.
2. We will provide you not less than 10 days notice if this policy is cancelled because you failed to pay a premium or remit an amount due because of an endorsement for a deductible when due.
3. We will provide you not less than 30 days notice for any other cancellation reason permitted under Nevada law, including failure to pay additional premium charged due to an audit of any payroll under the terms of the current or previous policy.
4. No policy of industrial insurance that has been in effect for at least 70 days or that has been renewed may be cancelled, except on any one of the following grounds:
   a. A failure by the policyholder to pay a premium for the policy of industrial insurance when due, including the failure of the policyholder to remit an amount due because of an endorsement for a deductible;
   b. A failure by the policyholder to:
      (1) Report any payroll;
      (2) Allow the insurer to audit any payroll in accordance with the terms of the policy or any previous policy issued by the insurer; or
      (3) Pay any additional premium charged because of an audit of any payroll as required by the terms of the policy or any previous policy issued by the insurer;
   c. A material failure by the policyholder to comply with any federal or state order concerning safety or any written recommendation of the insurer's designated representative for loss prevention;
   d. A material change in ownership of the policyholder or any change in the policyholder's business or operations that:
      (1) Materially increases the hazard for frequency or severity of loss;
      (2) Requires additional or different classifications for the calculation of premiums; or
      (3) Contemplates an activity that is excluded by any reinsurance treaty of the insurer;

e. A material misrepresentation made by the policyholder; or

f. A failure by the policyholder to cooperate with the insurer in conducting an investigation of a claim.

5. We cannot cancel the policy when the referenced reasons are corrected by you within the time specified in the written notice of cancellation.

B. Nonrenewal

1. We may elect not to renew the policy. We will provide to you a written notice of our intention not to renew at least 60 days before the expiration date.

2. We need not provide notice of our intention not to renew if you have accepted replacement coverage, if you have requested or agreed to nonrenewal, or if the policy is expressly designated as nonrenewable.

C. Information About Claims Paid

1. If you request information for the renewal of the policy, we will provide you with information regarding claims paid on your behalf.

2. We will provide the information within 30 working days after we receive your written request. We may charge a reasonable fee for providing the information.

D. Notices

1. We will provide advance written notice of cancellation or nonrenewal as provided in A and B above. This notice must be served personally on or sent by first-class mail or electronic transmission to the employer.

2. Notices will state the effective date of the cancellation or nonrenewal and will be accompanied by a written explanation of the specific reasons for the cancellation or nonrenewal.

3. A written notice of cancellation is not required if we mutually agree with you to cancel the policy and reissue a new policy based upon a material change in ownership or operation of your business.

E. Compliance with Law

1. Any of these provisions that conflict with a law that controls the cancellation or renewal or nonrenewal of the insurance in this policy is changed by this statement to comply with the law.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE CERTIFIED MANAGED CARE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

You may receive up to a ten percent (10%) premium credit if you subscribe to the services of an approved Managed Care Program.

In order to receive this credit, you are enrolled by your insurance company or subscribe individually to obtain the services of a Certified Managed Care Program. Certified Managed Care Programs are programs that are approved by the New Hampshire Department of Labor and ratified by the New Hampshire Advisory Council on Workers Compensation.

The managed care credit is to be applied in a multiplicative manner, after application of the experience modification factor. Also, all other credits/debits must be applied in a multiplicative manner, after the application of the experience modification factor and the managed care credit and before the application of the expense constant or premium discount, if any.

The credit can only be issued at inception of the policy. Minimum premium policies are not eligible for this credit. The credit is not applicable to assigned risk policies.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Five - Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

In accordance with NH ST 412:35, if you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we will apply an Audit Noncompliance Charge equal to three times the estimated annual premium and set the estimated premium as the final premium.

Upon receipt of notification of the ANC penalty charge and final premium, you will have an additional 10 days to request that the ANC penalty charge be waived and the final premium be recalculated based on actual exposure by completing the audit. We will not deny a timely request by you for a waiver and recalculation. Your request will be granted upon completion of the audit.

Failure to cooperate with this policy provision may result in the cancellation of your insurance coverage, as specified under the policy.

Note:

For coverage under state-approved workers compensation assigned risk plans, failure to cooperate with this policy provision may affect your eligibility for coverage.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE SOLE REPRESENTATIVE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Condition E, "Sole Representative," of the policy is replaced by the following:

"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 or to give us notice of cancellation. If we cancel this policy, we will give each named insured notice of cancellation."

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW HAMPSHIRE AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

For New Hampshire coverage, the Cancellation condition of the policy is amended and replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us.
2. We may cancel this policy. We will file a written termination notice with the Commissioner of the Department of Labor and will send a copy to you.
3. In case of nonpayment of premium, the cancellation will take effect 30 days after the termination notice is filed.
4. In case of cancellation for reasons other than nonpayment of premium, cancellation will take effect 45 days after the notice of termination is filed.
5. If you have obtained coverage from another insurance carrier or have qualified as a self-insurer, cancellation is effective on the date you obtained the coverage or qualified as a self-insurer.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New Jersey is shown in Item 3.A. of the Information Page.

With respect to Exclusion C5, this insurance does not cover any and all intentional wrongs within the exception allowed by N.J.S.A. 34:15-8 including but not limited to, bodily injury caused or aggravated by an intentional wrong committed by you or your employees, or bodily injury resulting from an act or omission by you or your employees, which is substantially certain to result in injury.

With respect to Exclusion C7, we will defend any claim, proceeding or suit for damages where bodily injury is alleged. We have the right to investigate and settle. We will not defend or continue to defend after the applicable limits of the insurance have been paid. Such policy limits include any legal costs assessed against you on behalf of your employee(s).

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to an infant under the age of 18 years in a proceeding made pursuant to Article 2 as provided in N.J.S.A. 34:15-10.

This insurance does not provide for the payment of any common law negligence damages or other damages when the provisions of Article 2 of the New Jersey Workers Compensation Law have been rejected by you and your employee(s) as provided in N.J.S.A. 34:15-9.

With respect to paragraph F., the "Other Insurance" provisions is replaced with the following:

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.

This insurance, however, is excess over any other applicable insurance with respect to claims for bodily injury arising out of employer practices, policies, acts or omissions enumerated in C7 above, whether such other insurance is stated to be primary, contributory, excess, contingent or otherwise.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because New York is shown in Item 3.A. of the Information Page.

We may not limit our liability to pay damages for which we become legally liable to pay because of bodily injury to your employees if the bodily injury arises out of and in the course of employment that is subject to and is compensable under the Workers' Compensation Law of New York.

Countersigned by _____
Authorized Representative

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

The New York Construction Classification Premium Adjustment Program (NYCCPAP) allows premium credits for some employers in the construction industry. These credits exist to recognize the difference in wage rates between employers within the same construction industries in New York.

Credits are earned for average wages in excess of $23.24 per hour for each eligible class. If your policy shows one of the following classification codes, and you are experience rated, you are eligible to apply for an NYCCPAP credit:

0042	5057	5193	5429	5491	5606	6003	6229	6325	9526
3365	5059	5213	5443	5506	5610	6005	6233	6400	9527
3724	5069	5221	5445	5507	5645	6017	6235	6701	9534
3726	5102	5222	5462	5508	5648	6018	6251	7536	9539
3737	5160	5223	5473	5536	5651	6045	6252	7538	9545
5000	5183	5348	5474	5538	5701	6204	6306	7601	9549
5022	5184	5402	5479	5545	5703	6216	6319	7855	9553
5037	5188	5403	5480	5547	5709	6217		8227	
5040	5190	5428							

If you have any eligible classes on your policy, you should have been notified by your insurance carrier or the New York Compensation Insurance Rating Board approximately four months prior to the inception date of this policy. If you believe you may be eligible for a credit and have not received an application, you should immediately contact your agent, insurance carrier, or the New York Compensation Insurance Rating Board.

The basis for determining the credit is the limited payroll of each employee for the number of hours worked (excluding overtime premium pay) for each construction classification (other than employees engaged in the construction of one or two-family residential housing). For policies with effective dates between January 1 and March 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the second calendar year preceding the policy effective date. For policies with effective dates between April 1 and December 31, the payroll submitted is for the third quarter, as reported to taxing authorities, for the calendar year preceding the policy effective date. Total payroll (and not limited payroll) is to be reported for employees engaged in the construction of one or two-family residential housing.

Credits are calculated by the New York Compensation Insurance Rating Board. Completed applications can be submitted to: Attention: Audit Division, New York Compensation Insurance Rating Board, 733 Third Avenue, New York, New York 10017, email: cpap@nycirb.org or via entry on the CPAP online application on the Rating Board's website http://www.nycirb.org/cpap.

The application for credit on a renewal policy must be received by the Rating Board three (3) months prior to the policy renewal effective date. The Rating Board will accept and process an application if it is received between the renewal policy effective and expiration date, however, it must be accompanied with an explanation from the employer stating the reason for the delay.

Under no circumstances will an original application be accepted for any policy if it is received after the expiration date of the policy to which the credit would have applied, nor will a revised application be accepted if it is received later than one (1) year from the expiration date of the policy to which the credit would have applied.

The New York Workers' Compensation and Employers' Liability Insurance Manual, and not this endorsement, govern the implementation and use of the NYCCPAP.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK MERIT RATING ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The premium and rates for this insurance are subject to merit rating because your premium is less than the amount necessary to be eligible for experience rating. A merit rating adjustment will not be applied if your final premium is calculated to be the New York minimum premium for the insured classifications.

The following credits or debits will be applied to your manual premium based on your claims during the most recent three-year period for which statistics are available.

1. An 8% credit will be applied if you had no claims.
2. A 0% debit will be applied if you had one claim.
3. A 4% debit will be applied if you had two claims.
4. An 8% debit will be applied if you had three or more claims.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK MERIT RATING REVISION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement is added to Part Five - Premium of the Policy.

The premium for the policy is adjusted by a Merit Rating Factor. The factor shown on the Information Page may be revised and applied to the policy in accordance with our manuals and endorsements.

We will issue an endorsement to show the revised factor, if different from the factor shown, when it is calculated.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK WORKERS' COMPENSATION
POLICYHOLDER NOTICE OF RIGHT TO APPEAL

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Policyholder Disputes

Policyholders are entitled to inquire, challenge and dispute issues relating to classification, ownership, premium auditing, and/or other New York Compensation Insurance Rating Board ("Rating Board") rulings or decisions pertaining to this policy. Please refer to the New York Workers' Compensation Policyholder Notice of Right to Appeal process noted below.

Inquiries may also be directed to the New York State Department of Financial Services (DFS) at:

http://www.dfs.ny.gov/about/contactus.htm#consumer

or by calling the Consumer Hotline at 800-342-3736
(Monday through Friday, 8:30 AM to 4:30 PM).

New York Workers' Compensation Policyholder Notice of Right to Appeal Process

An insured, or its representative (hereafter referred to as "insured"), may appeal the application of a rule or procedure contained in the New York Workers' Compensation & Employers' Liability Manual. Rules or procedures are defined as those determinations either by a carrier or the Rating Board, which define the variables which make up the policy conditions. Examples include: classification codes, ownership information, premium audits, and any other determination which may affect the policy.

To be considered for a review, a written request explaining the reason(s) for the appeal must be submitted to the Rating Board. Upon receipt of the request for review, the following actions will be taken:

1. The Rating Board will review the request and respond to the parties within sixty (60) days, either granting the parties or their authorized representatives their request or sustaining the Rating Board's original ruling.
2. If not satisfied with the outcome of **1.** above, the parties may then request, in writing, a conference with members of the Rating Board staff. The request must state the nature of the complaint and supply any supporting documents. The appropriate Department Vice President or his or her designated representative will preside at the conference.
3. If the dispute is not resolved by the conference, the parties may then appeal to the Underwriting Committee of the Rating Board for a hearing to consider the staff ruling. This appeal must be in writing and must specify the reasons for the appeal and the nature of the complaint.

   Following the Committee's receipt of the appeal request, the parties will be notified about the time and place for the hearing. The appeal will be heard at the next Underwriting Committee meeting for which appropriate time can be devoted to the matter. After the hearing, the parties will be advised, in writing, of the Underwriting Committee decision on the compliant.
4. If the Underwriting Committee ruling is not satisfactory to either party, then the aggrieved party may request a hearing at the New York State Department of Financial Services to consider the disputed decision.
5. The decision of the New York State Department of Financial Services may be appealed to a court of law, by the parties involved or the Rating Board.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by this Condition:

D. **Cancellation and Nonrenewal**

1. You may cancel this policy.

   If you cancel this policy, you must mail or deliver advance written notice to us stating when the cancellation is to take effect.

2. We may cancel this policy.

   (a) If this policy has been in effect for fewer than 60 days and is not a renewal policy, we may cancel this policy for any reason by giving you at least 30 days prior written notice of cancellation and the reasons for cancellation by registered or certified mail, return receipt requested.

   (b) If this policy has been in effect for at least 60 days or is a renewal policy, we may not cancel this policy without your prior written consent, except for any one of the following reasons:

   (1) Nonpayment of premium in accordance with the policy terms.

   (2) An act or omission by you or your representative that constitutes material misrepresentation or nondisclosure of a material fact in obtaining the policy, continuing the policy, or presenting a claim under the policy.

   (3) Increased hazard or material change in the risk assumed that could not have been reasonably contemplated by you and us at the time of assumption of the risk.

   (4) Substantial breach of contractual duties, conditions, or warranties that materially affects the insurability of the risk.

   (5) A fraudulent act against us by you or your representative that materially affects the insurability of the risk.

   (6) Willful failure by you or your representative to institute reasonable loss control measures that materially affect the insurability of the risk after written notice by us.

   (7) Loss of faculative reinsurance or loss of or substantial changes in applicable reinsurance as provided in G.S. 58-41-30.

   (8) Your conviction of a crime arising out of acts that materially affect the insurability of the risk

   (9) A determination by the Commissioner that the continuation of this policy would place us in violation of the laws of North Carolina.

   (10) You fail to meet the requirements contained in our corporate charter, articles of incorporation, or bylaws, when we are a company organized for the sole purpose of providing members of an organization with insurance coverage in North Carolina.

(c) If we cancel for any of the reasons listed in paragraph (b), we must provide you with at least 15 days prior written notice of cancellation stating the precise reason for cancellation. We may provide this notice by registered or certified mail, return receipt requested, to you and any other person designated in the policy to receive notice of cancellation at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Whenever notice of cancellation is given by registered or certified mail, cancellation will not be effective unless and until that method is employed and completed. Notice of intent to cancel given by registered or certified mail shall be conclusively presumed completed three days after the notice is sent if, on the same day that notice is sent by registered or certified mail, the insurer also provides notice by first-class mail and by electronic means if available as defined in G.S. 58-2-255(a) to the insured and any other person designated in the policy to receive notice. Any such supplemental notice given by electronic means shall be effective for the limited purpose of establishing this conclusive presumption. Notice of cancellation may also be given by anymethod permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure. Failure to send notice as provided in this paragraph to any other person designated in the policy to receive notice of cancellation invalidates the cancellation only as to that other person's interest.

(d) Cancellation for nonpayment of premium is not effective if the amount due is paid before the effective date stated in the notice of cancellation.

3. We may refuse to renew this policy.

(a) If this policy is for a term of one year or less, we must provide you with notice of nonrenewal at least 45 days prior to the expiration date of the policy.

(b) If this policy is for a term of more than one year or for an indefinite term, then to nonrenew the policy at the policy anniversary date we must provide you with notice of nonrenewal at least 45 days prior to the anniversary date of the policy.

(c) The notice of nonrenewal must state the precise reason for nonrenewal. Failure to send this notice, as provided in paragraphs 3 and 5, to any other person designated in the policy to receive this notice invalidates the nonrenewal only as to that other person’s interest.

(d) Any nonrenewal attempted or made that is not in compliance with paragraphs (a), (b) and (c) is not effective. Paragraphs (a), (b) and (c) do not apply if you have obtained insurance elsewhere, have accepted replacement coverage, or have requested or agreed to nonrenewal.

4. Whenever we lower coverage limits, raise deductibles, or raise premium rates for reasons within our exclusive control and other than at your request, we will mail you written notice of the change at least 30 days in advance of the effective date of the change. As used in this paragraph, the phrase, "reasons within our exclusive control" does not mean experience modification changes, exposure changes, or loss cost rate changes.

5. We must provide the notice required by paragraphs 3 and 4 by mail to you and any other person designated in the policy to receive this notice at the addresses shown in the policy or, if not indicated in the policy, at the last known addresses. Mailing copies of the notice by regular first-class mail satisfies the notice requirements of paragraphs 3, 4 and 5.

6. We will also send copies of the notice required by this endorsement to the agent or broker of record, though failure to send copies of the notice to the agent or broker of record will not invalidate a cancellation or nonrenewal. Mailing copies of the notice by regular first-class mail to the agent or broker of record satisfies the requirements of this paragraph. Notice of nonrenewal may also be given by any method permitted for service of process pursuant to Rule 4 of the North Carolina Rules of Civil Procedure.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA EMPLOYERS LIABILITY
INTENTIONAL TORT EXCLUSION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Part Two – Employers Liability Insurance, C – Exclusions, 5. is replaced by the following:

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury that you knew or should have known was substantially certain to occur from an act caused, committed, or aggravated by you;

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA MERIT RATING ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies to the insurance provided by Part One (Workers Compensation Insurance) because the state(s) listed in the Schedule below are shown in Item 3.A. of the Information Page.

The premium for this insurance is subject to the merit rating modification shown in the Schedule below because your premium is less than the amount necessary to be eligible for experience rating. Insureds certified for premium reductions under the Workers' Compensation Premium Reduction (WCRP) are not eligible for merit rating.

The premium for this insurance is subject to the merit rating modification shown in the Schedule because your premium is less than the amount necessary to be eligible for experience rating and is based on time-loss claims made during the most recent one-year period for which statistics are available. Upon request, the insurer will provide additional safety plan information to an employer who develops a debit merit rating adjustment.

SCHEDULE

Merit Rating Modification

State	No Claims (Percentage Credit)	One Claim (Percentage Debit/Credit)	Two or More Claims (Percentage Debit)
OK			

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition in Part Six (Conditions) of the policy is amended by adding the following provision:

5. If this policy has been in effect for more than 45 business days or is a renewal policy, we may cancel only for one of the following reasons:
   a. Nonpayment of premium;
   b. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted under it;
   c. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;
   d. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;
   e. A violation of local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against;
   f. A determination by the Insurance Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;
   g. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or
   h. Loss of or substantial changes in applicable reinsurance.

Part 6 (Conditions) of the policy is amended by adding the following provisions:

F. Nonrenewal

If we elect not to renew this policy, we will mail or deliver written notice of nonrenewal to you at least 45 days before:

a. The expiration date of this policy; or
b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

Any notice of nonrenewal will be mailed or delivered to you at the last mailing address known to us.

If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.
b. Proof of mailing will be sufficient proof of notice.

If notice of nonrenewal is not mailed or delivered at least 45 days before the expiration date or an anniversary date of this policy, coverage will remain in effect until 45 days after notice is given. Earned premium for such extended period of coverage will be calculated pro rata based on the rates applicable to the expiring policy.

We will not provide notice of nonrenewal if:

a. We, or another company within the same insurance group, have offered to issue a renewal policy; or

b. You have obtained replacement coverage or have agreed in writing to obtain replacement coverage.

If we have provided the required notice of nonrenewal as described above, and thereafter extend the policy for a period of 90 days or less, we will not provide an additional nonrenewal notice with respect to the period of extension.

G. Notice of Premium or Coverage Changes Upon Renewal

If we elect to renew this policy, we will give written notice of any premium increase, change in deductible, or reduction in limits or coverage, to you, at the last mailing address known to us.

Any such notice will be mailed or delivered to you at least 45 days before:

a. The expiration date of this policy; or

b. An anniversary date of this policy, if it is written for a term longer than one year or with no fixed expiration date.

If notice is mailed:

a. It will be considered to have been given to you on the day it is mailed.

b. Proof of mailing will be sufficient proof of notice.

If you accept the renewal, the premium increase or deductible, limits or coverage changes will be effective the day following the prior policy's expiration or anniversary date.

If notice is not mailed or delivered at least 45 days before the expiration date or anniversary date of this policy, the premium, deductible, limits and coverage in effect prior to the changes will remain in effect until the earlier of

a. 45 days after notice is given; or

b. The effective date of replacement coverage obtained by you.

If you then elect not to renew, any earned premium for the resulting extended period of coverage will be calculated pro rata at the lower of the new rates or rates applicable to the expiring policy.

We will not provide notice of the following:

a. Changes in a rate or plan filed with or approved by the Insurance Commissioner or filed pursuant to the Property and Casualty Competitive Loss Cost Rating Act and applicable to an entire class of business; or

b. Changes based upon the altered nature of extent of the risk insure; or

c. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA FRAUD WARNING ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OKLAHOMA ELECTION OF COVERAGE NOTIFICATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

NOTICE: YOU HAVE THE OPTION TO ELECT TO INCLUDE, AS APPLICABLE, YOUR SOLE PROPRIETOR, ANY OR ALL OF YOUR PARTNERSHIP MEMBERS, ANY OR ALL OF YOUR LIMITED LIABILITY COMPANY MEMBERS, OR ANY OR ALL OF YOUR STOCKHOLDER-EMPLOYEES AS EMPLOYEES FOR THE PURPOSE OF WORKERS COMPENSATION INSURANCE COVERAGE BY ENDORSING THE POLICY IN ACCORDANCE WITH SECTION 3 OF TITLE 85 OF THE OKLAHOMA STATUTES.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OREGON PREMIUM DUE DATE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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 specified in the billing invoice for that policy.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OREGON CANCELLATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The **Cancellation** Condition of the policy is replaced by this Condition:

D. **Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us, stating when the cancellation is to take effect. If you provide for other insurance or self-insurance, your cancellation of coverage will take effect upon the effective date of that insurance.
2. We may cancel this policy. We will mail to you advance written notice stating when the cancellation is to take effect.
   a) If we cancel, based on our decision not to offer insurance to all employers within your premium category, we will mail the notice of cancellation at least 90 days before the cancellation is to take effect.
   b) If we cancel for other reasons, we will mail the notice of cancellation at least 45 days before the cancellation is to take effect.
   c) If we cancel for nonpayment, we will mail notice of cancellation at least 10 days before the cancellation is to take place.
3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.
4. The policy period will end at 12 midnight on the day stated in the cancellation notice.
5. When coverage is placed with another carrier as of the policy expiration date, a rejected renewal policy shall be withdrawn without charge, providing notice of nonrenewal is mailed and postmarked on or before the expiration date and is received from the insured by the insurer no later than 10 calendar days after said expiration date.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

OREGON AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Part Two - Employers Liability Insurance, Section C. (Exclusions), Item 5. of the policy is replaced by the following:

5. Any bodily injury intentionally caused or aggravated by you, or that is the result of your engaging in conduct equivalent to an intentional tort, however defined, including as described by ORS 656.156, or other tortious conduct, or conduct or activity as described by ORS 656.018(3), such that you lose your immunity from civil liability under the workers compensation laws of Oregon;

Part Two - Employers Liability Insurance, Section C. (Exclusions) of the policy is revised by adding the following:

13. Any cause of action or remedy arising out of or under ORS 656.019 or ORS 654.305 through ORS 654.336.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENNSYLVANIA AUDIT NONCOMPLIANCE CHARGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Part Five - Premium, Section G. (Audit) of the Workers Compensation and Employers Liability Insurance Policy is revised by adding the following:

If you do not allow us to examine and audit all of your records that relate to this policy, and/or do not provide audit information as requested, we may apply an Audit Noncompliance Charge (ANC).

The charge is determined by applying the ANC Multiplier to the ANC Basis shown in the table below:

ANC Basis	ANC Multiplier
Estimated Annual Premium	Two times

If you allow us to examine and audit all of your records after we have applied an ANC, we will remove the ANC and revise your premium in accordance with our manuals and Part 5 - Premium, E. (Final Premium) of this policy.

The application of the ANC is subject to the following conditions:

a) Carriers must comply with all applicable state laws and/or regulations related to audits of workers compensation insurance policies.

b) The Audit Noncompliance Charge Endorsement is optional. When used, the Audit Noncompliance Charge Endorsement and/or applicable state-specific endorsement must be attached to the policy at inception of the policy term being audited.

c) The carrier must make two attempts to obtain the audit information and/or complete the audit. At each attempt, the carrier must notify the employer regarding the specific required records and the amount of the ANC to be applied if the employer continues to refuse to comply with the audit.

d) The carrier must adequately document the audit file regarding the above attempts to obtain the required audit information.

These ANC conditions apply to mail/email, telephone, computer (remote access), and physical audits, unless otherwise provided by state law.

The scenarios listed below may occur and are treated as follows:

<table>
<tr><th>If an ANC is applied and the employer…</th><th>Then the carrier…</th></tr>
<tr><td>Pays the ANC and later allows the audit</td><td>o Performs the final audit and determines the final policy premium based on the results of the audit; and

o Refunds the ANC to the employer, or applies the ANC amount to any outstanding balance on the policy

Submits a unit statistical correction report to remove the ANC from the previously reported Unit Statistical data.</td></tr>
<tr><td>Does not pay the ANC but later allows the audit</td><td>Performs the final audit and determines the final policy premium based on the results of the audit</td></tr>
<tr><td>Pays the ANC but does not later allow the audit</td><td rowspan="2">Does not change the previously reported:
o Unit Statistical data
o Noncompliance transactions</td></tr>
<tr><td>Does not pay the ANC and does not later allow the audit.</td></tr>
</table>

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SPECIAL PENNSYLVANIA ENDORSEMENT - INSPECTION OF MANUALS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

The manuals of rules, rating plans, and classifications are approved pursuant to the provisions of Section 654 of the Insurance Company Law of May 17, 1921, P. L. 682, as amended, and are on file with the Insurance Commissioner of the Commonwealth of Pennsylvania.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENNSYLVANIA NOTICE

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

An Insurance Company, its agents, employees or service contractors acting on its behalf, may provide services to reduce the likelihood of injury, death or loss. These services may include any of the following or related services incident to the application for, issuance, renewal or continuation of, a policy of insurance:

1. surveys;
2. consultation or advice; or
3. inspections.

The "Insurance Consultation Services Exemption Act" of Pennsylvania provides that the Insurance Company, its agents, employees or service contractors acting on its behalf, is not liable for damages from injury, death or loss occurring as a result of any act or omission by any person in the furnishing of or the failure to furnish these services.

The Act does not apply:

1. if the injury, death or loss occurred during the actual performance of the services and was caused by the negligence of the Insurance Company, its agents, employees or service contractors;
2. to consultation services required to be performed under a written service contract not related to a policy of insurance; or
3. if any acts or omissions of the Insurance Company, its agents, employees or service contractors are judicially determined to constitute a crime, actual malice, or gross negligence.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

PENNSYLVANIA ACT 86-1986 ENDORSEMENT NONRENEWAL, NOTICE OF INCREASE OF PREMIUM, AND RETURN OF UNEARNED PREMIUM

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The policy conditions are amended by adding the following regarding nonrenewal, notice of increase in premium, and return of unearned premium.

Nonrenewal

1. We may elect not to renew the policy. We will mail each named insured, by first class mail, not less than 60 days advance notice stating when the nonrenewal will take effect. Mailing that notice to you at your mailing address last known to us will be sufficient to prove notice.
2. Our notice of nonrenewal will state our specific reasons for not renewing.
3. If we have indicated our willingness to renew, we will not send you a notice of nonrenewal. However, the policy will still terminate on its expiration date if:
   a. you notify us or the agent or broker who procured this policy that you do not want the policy renewed; or
   b. you fail to pay all premiums when due; or
   c. you obtain other insurance as a replacement of the policy

Notice of Increase in Premium

1. We will provide you with not less than 30 days advance notice of an increase in renewal premium of this policy, if it is our intent to offer such renewal.
2. The above notification requirement will be satisfied if we have issued a renewal policy more than 30 days prior to its effective date.
3. If a policy has been written or is to be written on a retrospective rating plan basis, the notice of increase in premium provision of this endorsement does not apply.

Return of Unearned Premium

1. If this policy is canceled and there is unearned premium due you:
   a. If the Company cancels, the unearned premium will be returned to you within 10 business days after the effective date of cancellation.
   b. If you cancel, the unearned premium will be returned within 30 days after the effective date of cancellation.

2. Because this policy was written on the basis of an estimated premium and is subject to a premium audit, the unearned premium specified in 1a. and 1b. above, if any, shall be returned on an estimated basis. Upon our completion of computation of the exact premium, an additional return premium or charge will be made to you within 15 days of the final computation.

3. These return or unearned premium provisions shall not apply if this policy is written on a retrospective rating plan basis.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

RHODE ISLAND SHORT RATE CANCELLATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The cancellation condition in the Workers Compensation and Employers Liability Insurance Policy Part Five Premium, E. Final Premium, states that if this policy is cancelled by you, the final premium will be more than pro rata but not less than the policy minimum premium.

The final premium will be calculated as follows based on the Short Rate Cancellation Table attached to this endorsement:

If….	Then…
This policy is cancelled by you, except when retiring from this business	Unless a different method has been filed by the carrier and approved by the appropriate regulatory authority, the premium for the cancelled policy must be calculated by using either the short-rate **percentage** or short-rate **factor** as follows, based on the Short-Rate Cancellation Table located in Appendix B: Steps based on short-rate percentage: 1. Determine the payroll developed during the period the policy was in effect. 2. Determine the full policy payroll by using the following formula: $\frac{\text{number of days for which the policy was written}}{\text{number of days the policy was in effect}}$ x actual payroll 3. Apply authorized rates to such payroll. 4. Calculate the extended number of days by using the following formula. If the policy was written for a one-year period, the extended number of days is the number of days the policy was in effect: $\frac{\text{number of days the policy was in effect}}{\text{number of days for which the policy was written}}$ x 365 5. Based on the extended number of days, apply the short rate **percentage** shown in the **Short Rate Cancellation Table** located in the Appendix to the full policy premium calculated in step 3. This result is the short-rate manual premium.

	6. If applicable: o Apply any pricing programs o Apply any experience rating modification o Apply any premium discount based on the final earned total standard premium o Add the short-rate portion of the expense constant but not less than $15 o Apply catastrophe provisions based on the earned manual premium 7. The total earned premium for the short-rate cancelled policy must not be less than the annual minimum premium applicable to the policy. Steps based on the short-rate **factor**: 1. Determine the payroll developed during the period that the policy was in effect. 2. Apply authorized rates to such payroll. 3. Based on the number of days that the policy was in effect, determine the applicable short-rate **factor** shown in the **Short Rate Cancellation Table** located in Appendix B. 4. Apply the short-rate **factor** to the premium calculated on the basis of the earned premium for the period that the policy was in effect in step 2. This result is the short-rate manual premium. 5. If applicable: o Apply any pricing programs o Apply any experience rating modification o Apply any premium discount based on the final earned total standard premium o Add the short rate portion of the expense constant but not less than $15 o Apply catastrophe provisions based on the earned manual premium 6. The total earned premium for the short-rate cancelled policy must not be less than the annual minimum premium applicable to the policy.

SHORT RATE CANCELLATION TABLE

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

SHORT RATE CANCELLATION TABLE (cont'd)

Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factor to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

RHODE ISLAND DIRECT LIABILITY STATUTE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because Rhode Island is shown in Item 3.A. of the Information Page.

1. Your employee, or the persons entitled to sue you for damages in the event of the death of the employee, may add us as a defendant in a suit against you to recover damages because of bodily injury or death to your employee.
2. We are directly liable to pay to your injured employee, or to the persons entitled to sue you for damages in the event of the death of your employee, the damages for which you are liable.

This endorsement is subject to all provisions of Part Two (Employers Liability Insurance) that do not conflict with the direct liability statute (Section 28.36.11) of the Rhode Island Workers' Compensation Law.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

RHODE ISLAND
SAFETY INSPECTION
ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

If you pay annual premium of more than twenty-five thousand dollars ($25,000) for workers compensation insurance, you may request that we inspect your site or sites of employment. You must make this request in writing. Inspection will be made within sixty days following your request. We will make a written report to you for your use in enhancing the safety and health of your employees on the site or sites inspected.

If your workers compensation premiums are less than fifty thousand dollars ($50,000) or your experience modification is less than 1.5, you may request one (1) inspection per calendar year. you may be entitled to two (2) such inspections in one (1) calendar year.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

GENERAL SECTION

B. **Who Is Insured** is amended to read:
You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership or joint venture, and if you are one of its partners or members, you are insured, but only in your capacity as an employer of the partnership's or joint venture's employees.

D. **State** is amended to read:
State means any state or territory of the United States of America, and the District of Columbia.

PART ONE - WORKERS COMPENSATION INSURANCE

E. **Other Insurance** is amended by adding this sentence:
This Section only applies if you have other insurance or are self-insured for the same loss.

F. **Payments You Must Make**
This Section is amended by deleting the words "workers compensation" from number 4.

H. **Statutory Provisions**
This Section is amended by deleting the words "after an injury occurs" from number 2.

PART TWO - EMPLOYERS LIABILITY INSURANCE

C. **Exclusions**
Sections 2 and 3 are amended to add:
This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.
Section 6 is amended to read:
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, Mexico or Canada who is temporarily outside these countries.

D. **We Will Defend**
This Section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:
6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. **Our Manuals** is amended by adding this sentence:
In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.

C. Remuneration

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers compensation insurance.

E. Final Premium

Number 2 is amended to read:

2. If you 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.

PART SIX - CONDITIONS

A. **Inspection** is amended by adding this sentence:
Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be canceled by us.

C. **Transfer of Your Rights and Duties** is amended to read:
Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

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

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Department of Insurance-Division of Workers' Compensation.
3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:
   a. Fraud in obtaining coverage;
   b. Misrepresentation of the amount of payroll for purposes of premium calculation;
   c. Failure to pay a premium when payment was due;
   d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control;
   e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public.
4. If another insurance company notifies the Texas Department of Insurance-Division of Workers' Compensation that it is insuring you as an employer, such notice must be a cancellation of this policy effective when the other policy starts.

Add the following to the policy:

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. **Claims Notification**

We are required to notify you of any claim that is filed against your policy. Thereafter we must notify you of any proposal to settle a claim or, on receipt of a written request from you, of any administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Department of Insurance-Division of Workers' Compensation. You may, in writing, elect to waive this notification requirement.

We must, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE:

DISPUTE RESOLUTION SERVICES

NCCI'S DISPUTE RESOLUTION PROCESS DOES NOT APPLY TO WORKERS COMPENSATION CLAIMS.

For workers compensation claim disputes, see "CLAIM COMPLAINT" below. For issues related to a violation of law related to your policy, see "VIOLATIONS OF LAW" below.

Important Note: The dispute resolution services provided through the Dispute Resolution Process (Process) of the National Council on Compensation Insurance (NCCI) are **voluntary**. The Process is not an administrative remedy that must be exhausted before you pursue relief in court. Using the Process does not prevent you or the carrier that issued the policy from pursuing any available legal remedies at any time.

NCCI can assist in the resolution of a dispute regarding your policy that is related to any of the following matters:

- The application or interpretation of rules contained in the various NCCI manuals (including, but not limited to, classification codes and experience rating modifications)
- Rating programs
- Endorsements
- Forms

Contact the carrier that issued the policy and attempt to resolve the dispute directly. If you and the carrier cannot agree, then contact NCCI to ask for assistance. NCCI's **Basic Manual** addresses dispute resolution in Appendix G. You may obtain dispute resolution services only after you have made a reasonable attempt to first resolve the dispute directly with the carrier and after you have paid any undisputed premium due to the carrier.

Send your request for assistance by mail to NCCI, Dispute Resolution Services, 901 Peninsula Corporate Circle, Boca Raton, FL 33487-1362; or by fax to 561-893-5043; or by email to regulatoryoperations@ncci.com.

THIS NOTICE OF THE DISPUTE RESOLUTION PROCESS IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

VIOLATIONS OF LAW:

If you believe there has been a violation of law related to your policy, file a complaint with the Texas Department of Insurance:

Phone: 1-800-252-3439 **Online:** tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov **Mail:** MC 111-1A, PO Box 149091, Austin, TX 78714

CLAIM COMPLAINT:

If there is a workers compensation claim complaint involving one of your employees, then contact the Texas Department of Insurance - Division of Workers' Compensation, Compliance and Investigations by mail to 7551 Metro Center Drive, Suite 100, MS-8, Austin, TX 78744; or by fax to 512-490-1030; or by email to DWC-ComplianceReview@tdi.texas.gov.

THIS NOTICE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART, TERM, OR CONDITION OF THIS POLICY.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule, but this waiver applies only with respect to bodily injury arising out of the operations described in the Schedule where you are required by a written contract to obtain this waiver from us.

This endorsement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

The premium for this endorsement is shown in the Schedule.

Schedule

1. ( ) Special Waiver
   Name of person or organization

   (X) Blanket Waiver
   Any person or organization for whom the Named Insured has agreed by written contract to furnish this waiver.

2. Operations:
   All Texas Operations

3. Premium:
   The premium charge for this endorsement shall be 2 percent of the premium developed on payroll in connection with work performed for the above person(s) or organization(s) arising out of the operations described.

4. Advance Premium:

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE - PREMIUM

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. The billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

UTAH CANCELLATION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Cancellation Section (D) of Part Six – Conditions is replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. If this policy has been previously renewed or has been in effect for at least 60 days, the provisions of this paragraph 2 apply. We may cancel this policy for one of the following reasons:
   a. You fail to pay all premiums when due;
   b. A material misrepresentation;
   c. A substantial change in the risk assumed, unless we should reasonably have foreseen the change or contemplated the risk when entering into the contract;
   d. Substantial breaches of contractual duties, conditions or warranties.

   We will mail or deliver to you not less than 30 days advance written notice stating when the cancellation is to take effect, except in the event you fail to pay your premiums when due, in which case we will mail or deliver to you not less than 10 days advance written notice stating when the cancellation is to take effect. Should we cancel for non-payment of premiums, we must state this as the reason for the cancellation on our notice of cancellation. Should we cancel for any of the other reasons above, we must either state the facts on which our decision is based or notify you of your right to make a written request for that information. Mailing a cancellation notice via first class mail to you at your mailing address last known to us will be sufficient to prove notice.
3. If this policy has not previously been renewed and has been in effect less than 60 days, we may cancel the policy for any reason and without a statement of reasons. We will deliver to you not less than 10 days advance written notice stating when the cancellation is to take effect.
4. The policy period will end on the day and hour stated in the cancellation notice.

B. Renewal/Nonrenewal

1. You have the right to have the insurance renewed unless:
   a. The policy has been cancelled;
   b. The policy is expressly designated as nonrenewable;

c. You fail to pay the renewal premium by the due date. We will mail the renewal notice to you not more than 45 days nor less than 14 days prior to the renewal effective date. The renewal notice will include the estimated renewal premium, how it may be paid, and state that failure to pay the renewal premium by the due date extinguishes your right to the renewal; or

d. We give you 30 days notice of nonrenewal prior to the expiration or the anniversary date. We must deliver or send the notice by first class to your last known mailing address.

2. If we offer to renew the policy but on less favorable terms or at higher rates, the new terms or rates will take effect on the renewal date if we delivered or sent by first class mail to you notice of the new terms or rates at least 30 days prior of the expiration date of the prior policy. The prior notice requirement does not apply if the only change is a rate increase generally applicable to your class of business, a rate increase resulting from a classification change, or a policy form change made to make the form consistent with Utah law.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VIRGINIA AMENDATORY ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

For Virginia insurance, Part Six D. (Conditions-Cancellation) is replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us. You must provide written notice of your cancellation, including the date of and reasons for the cancellation, to the Workers Compensation Commission.

2. We may cancel this policy. We will provide you with 30 days notice of cancellation. We will provide the Workers Compensation Commission with immediate notice of such cancellation. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

3. In the event of cancellation by you or us, you must provide 30 days written notice of the cancellation to your covered employees.

4. We may nonrenew your policy. We will provide 30 days notice to you and to the Workers Compensation Commission of our decision to nonrenew. This provision does not apply if you have obtained other insurance and that insurer has notified the Workers Compensation Commission that it is now providing your insurance.

5. If you fail to pay the premium due on this policy we may cancel the policy by providing 10 days notice to you and to the Workers Compensation Commission.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WISCONSIN LAW ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

This policy is amended to reflect the following changes and/or additions to clarify or comply with Wisconsin Law:

I. If our agent has knowledge of a change in or a violation of a policy condition, this will be considered our knowledge and will not void the policy or defeat a recovery for a claim.

ll. "Workers Compensation Law" means Chapter 102, Wisconsin Statutes. It does not include and this policy does not apply to any obligation under Chapter 40, Wisconsin Statutes, or Section 66.191, Wisconsin Statutes, or any amendment to these laws.

III. Any language involving "Actions Against Us" is replaced and amended to provide that no legal action may be brought against us until there has been full compliance with all terms of this policy.

IV. If an injury occurs that may be covered by this insurance, the policy is amended to provide that you must notify us of that injury as soon as reasonably possible.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FOREIGN COVERAGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement supersedes any other Foreign Coverage Endorsement attached to this policy as respects Wisconsin employees. Foreign Coverage for Wisconsin employees is provided under Part One of the policy, at no additional charge.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WISCONSIN CANCELLATION AND NONRENEWAL ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The Cancellation Section (D) of the Part Six - Conditions is deleted and replaced by the following:

A. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect. If you purchase replacement insurance, the cancellation becomes effective on the date the new coverage becomes effective. If no replacement coverage is purchased, the cancellation will be effective thirty (30) days after receipt of written notice by the Wisconsin Compensation Rating Bureau.

2. We may cancel the policy for any reason if the policy has been in effect for less than sixty (60) days. If the policy is issued for a term longer than one year or for an indefinite term, we may cancel the policy for any reason on an annual anniversary of the policy effective date. We may cancel the policy at any other time for the following reasons:

   a. you fail to pay all premiums when due, however, we must deliver or mail, first class, not less than thirty (30) days advance written notice stating when the cancellation is to take effect;

   b. a material misrepresentation;

   c. a substantial breach of the obligations, conditions or warranties under the policy; or

   d. a substantial change in the risk we assumed under the policy unless it was reasonable for us to foresee the change or expect the risk when we issued the policy.

3. If we cancel for any permissible reason other than nonpayment of premium when due, we must deliver or mail, first class, not less than* thirty (30) days notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

4. The policy period will end on the day and hour stated in a notice of cancellation.

B. Nonrenewal

1. You have the right to have the insurance renewed unless we deliver or mail to you not less than* sixty (60) days advance written notice stating our intention not to renew this policy.

2. We do not have to renew the insurance if you do not pay the renewal premium billing by the due date or if you accept replacement insurance, are insured elsewhere, requested or agree to nonrenewal, or if the policy is expressly designated as being nonrenewable.

3. If we renew the insurance, we may use the policy forms, rates and rating plans we are then using for similar risks. We may limit the policy to a term equivalent to the term of the expiring policy or one year, whichever is less.

4. If we offer to renew the insurance on less favorable terms, we will mail or deliver written notice of the new terms by first class mail to you, the policy holder, at least sixty (60) days prior to the renewal date. The definition of "terms" does not include manual rates, experience modification factors, or classification of risks.

If we provide such notice within sixty (60) days prior to the renewal date, the new terms will not take effect until sixty (60) days after the notice is mailed or delivered, in which case, you, the policy holder, may elect to cancel the renewal policy at any time during the sixty (60) day period. The notice will include a statement of your right to cancel. If you elect to cancel the renewal policy during the sixty (60) day period, the return premium or additional premium charges shall be calculated proportionally on the basis of the old premiums.

We need not mail or deliver this notice if the only change adverse to you is a premium increase that; (a) is less than 25%; or, (b) results from a change based on your action that alters the nature and extent of the risk insured against, including, but not limited to, a change in the classifications for the business.

* Any written agreement attached to and made a part of the policy, between the insurance carrier and policyholder which extends the cancellation or nonrenewal notification timeframe, will supercede the aforementioned notification requirements found in items A.3., and B.1., respectively.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

EMPLOYERS' LIABILITY STOP GAP COVERAGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to work in the states shown in the Schedule.

I. Part One (Workers' Compensation Insurance) does not apply to work in a state shown in the Schedule.

II. Part Two (Employers' Liability Insurance) applies to work in the states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.

III. Part Two, Section C **Exclusions** is changed by adding these exclusions. This insurance does not cover:

5. bodily injury by accident or bodily injury by disease intentionally caused or aggravated by you, or bodily injury by accident or bodily injury by disease resulting from an act which is determined to have been committed by you if it was reasonable to believe that an injury is substantially certain to occur.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium payment under, or any other failure to comply with the provisions of the workers' compensation law or laws of a state shown in the Schedule.

SCHEDULE

State
OH
WA

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDATORY ENDORSEMENT
COLORADO

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

It is agreed that this policy covers all employees of the insured, including statutory employees, and covers all business operations of the insured in any lawful endeavors, whether naturally connected or not, with respect to compensation and other benefits required of the insured by the Workers Compensation Law.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COVID-19 REPORTING REQUIREMENT ENDORSEMENT - CALIFORNIA

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of California Insurer: Property and Casualty Insurance Company of Hartford

In addition to the requirements under Part 4, "Your Duties if Injury Occurs" of your policy, if you have five or more employees and an employee that is not described in California Labor Code section 3212.87 tests positive for COVID-19, you are required to report the following information as provided below.

Reporting COVID-19 Positive Tests from September 17, 2020 to January 1, 2023

Pursuant to California Labor Code Section 3212.88(i), when you know, or reasonably should know, that an employee has tested positive for COVID-19 between September 17, 2020 and January 1, 2023, within 3 business days you must report all of the following to your claims administrator in writing via electronic mail or facsimile:

(1) An employee has tested positive. For purposes of this reporting, do not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to California Labor Code Section 5401.

(2) The date that the employee tests positive, which is the date the specimen was collected for testing.

(3) The specific address or addresses of the employee's specific place of employment during the 14-day period preceding the date of the employee's positive test.

(4) The highest number of employees who reported to work at the employee's specific place of employment in the 45-day period preceding the last day the employee worked at each specific place of employment.

Labor Code Section 3212.88(j) states that the intentional submission of false or misleading information or the failure to report the above information as required may subject you to a civil penalty in the amount of up to $10,000 to be assessed by the Labor Commissioner.

For the purposes of these reporting requirements, California Labor Code Section 3212.88(m) provides the following:

(1) "COVID-19" means the 2019 novel coronavirus disease.

(2) “Test” or “testing” means a PCR (Polymerase Chain Reaction) test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA. “Test” or “testing” does not include serologic testing, also known as antibody testing. “Test” or “testing” may include any other viral culture test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA which has the same or higher sensitivity and specificity as the PCR Test.

(3) “A specific place of employment” means the building, store, facility, or agricultural field where an employee performs work at the employer’s direction. “A specific place of employment” does not include the employee’s home or residence, unless the employee provides home health care services to another individual at the employee’s home or residence.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00.
Section II of this endorsement provides additional coverage usually only provided by endorsement.
Section III of this endorsement is a Schedule of Covered States.
You may use the index to locate these coverage features quickly:

INDEX

SECTION I

PARTS ONE and TWO

1. WE WILL ALSO PAY

D. **We Will Also Pay** of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. **We Will Also Pay** of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. **Transfer Of Your Rights and Duties** of **Part 6** (Conditions) is replaced by the following:

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

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

4. Cancellation

Paragraph **2.** of **D. Cancellation** of **Part 6** (Conditions) is replaced by the following:

2. We may cancel this policy. We must mail or deliver to you not less than **15** days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

5. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

6. Voluntary Compensation Insurance

A. **How This Insurance Applies**

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.

4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of the officer's or employee's employment. The officer's or 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 6. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

7. Employers' Liability Stop Gap Coverage

A. This coverage only applies in Montana, North Dakota, Ohio, Washington, West Virginia and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief than an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

E. This insurance applies to damages for which you are liable under West Virginia Code Annot. S 23-4-2.

SECTION III

8. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

VA, AZ, IA, GA, UT, OK, RI, ME, IN, KS, NH

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00 A.
Section II of this endorsement provides additional coverage usually only provided by endorsement.
Section III of this endorsement is a Schedule of Covered States.
You may use the index to locate these coverage features quickly:

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SECTION I

PARTS ONE and TWO

1. WE WILL ALSO PAY

D. We Will Also Pay of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Cancellation

Paragraph **2.** of **D. Cancellation** of **Part 6** (Conditions) is replaced by the following:

2. We may cancel this policy. We must mail or deliver to you not less than **15** days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

5. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

6. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by an employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment necessary or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.

4. Bodily injury by accident must occur during the policy period.
5. 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 6. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

7. Employers' Liability Stop Gap Coverage

A. This coverage only applies in Montana, North Dakota, Ohio, Washington, and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief than an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

SECTION III

8. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

CT

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00 A.
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Process Date: 07/02/22 **Policy Expiration Date:** 08/11/23

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1. WE WILL ALSO PAY

D. We Will Also Pay of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 sixty days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Cancellation

Paragraph **2.** of **D. Cancellation** of **Part 6** (Conditions) is replaced by the following:

2. We may cancel this policy. We must mail or deliver to you not less than **15** days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

5. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

6. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by an employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment necessary or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.

4. Bodily injury by accident must occur during the policy period.
5. 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 6. does not apply in New Jersey or Wisconsin.

SECTION III

8. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

MA

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
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Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

5. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of the officer's or employee's employment.

The officer's or 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it.

If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 5. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

6. Employers' Liability Stop Gap Coverage

A. This coverage only applies in Montana, North Dakota, Ohio, Washington, West Virginia and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief than an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.

13. bodily injury sustained by any member of the flying crew of any aircraft.

14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

E. This insurance applies to damages for which you are liable under West Virginia Code Annot. S 23-4-2.

SECTION III

7. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

C. Schedule of Covered States:

NC, ID, CO, LA, NV, DC

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT EXTENDED OPTIONS

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00.
Section II of this endorsement provides additional coverage usually only provided by endorsement.
Section III of this endorsement is a Schedule of Covered States.
You may use the index to locate these coverage features quickly:

INDEX

SECTION I

PARTS ONE and TWO

1. WE WILL ALSO PAY

D. We Will Also Pay of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION ANDEMPLOYERS' LIABILITY COVERAGE

5. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of the

officer's or employee's employment. The officer's or 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 5. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

6. Employers' Liability Stop Gap Coverage

A. This coverage only applies in Montana, North Dakota, Ohio, Washington, West Virginia and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief than an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.

13. bodily injury sustained by any member of the flying crew of any aircraft.

14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

E. This insurance applies to damages for which you are liable under West Virginia Code Annot. S 23-4-2.

EXTENDED OPTIONS

1. Employers' Liability Insurance

Item 3.B. of the **Information Page** is replaced by the following:

B. Employers' Liability Insurance:

1. **Part Two** of the policy applies to work in each state listed in Item 3.A.

   The Limits of Liability under Part Two are the higher of:

Bodily Injury by Accident	**$500,000 Each Accident**
Bodily Injury by Disease	**$500,000 Policy Limit**
Bodily Injury by Disease	**$500,000 Each Employee**

OR

2. The amount shown in the Information Page.

This provision 1 of **EXTENDED OPTIONS** does not apply in New York because the Limits Of Our Liability are unlimited.

In this provision the limits are changed from **$500,000** to **$1,000,000** in California.

2. Unintentional Failure to Disclose Hazards

If you unintentionally should fail to disclose all existing hazards at the inception date of your policy, we shall not deny coverage under this policy because of such failure.

3. Waiver of Our Right To Recover From Others

A. We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against any person or organization for whom you perform work under a written contract that requires you to obtain this agreement from us.

   This agreement shall not operate directly or indirectly to benefit anyone not named in the agreement.

B. This provision 3. does not apply in the states of Pennsylvania and Utah.

4. Foreign Voluntary Compensation and Employers' Liability Reimbursement

A. How This Reimbursement Applies

This reimbursement provision applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must be sustained by an officer or employee.
2. The bodily injury must occur in the course of employment necessary or incidental to work in a country not listed in Exclusion C.1. of this provision.
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 officer or employee's last exposure to those conditions of your employment must occur during the policy period.

B. We Will Reimburse

We will reimburse you for all amounts paid by you whether such amounts are:

1. voluntary payments for the benefits that would be required of you if you and your officers or employees were subject to any workers' compensation law of the state of hire of the individual employee.
2. sums to which Part Two (Employers' Liability Insurance) would apply if the Country of Employment were shown in Item 3.A. of the Information Page.

C. Exclusions

This insurance does not cover:

1. any occurrences in the United States, Canada, and any country or jurisdiction which is the subject of trade or economic sanctions imposed by the laws or regulations of the United States of America in effect as of the inception date of this policy.
2. any obligation imposed by a workers' compensation or occupational disease law, or similar law.
3. bodily injury intentionally caused or aggravated by you.

4. liability for any consequence, whether direct or indirect, of war, invasion, act of Foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection or military or usurped power. No endorsement now or subsequently attached to this policy shall be construed as overriding or waiving this limitation unless specific reference is made thereto.

D. Before We Pay

Before we reimburse you for the benefits to the persons entitled to them, you must have them:

1. release you and us, in writing, of all responsibility for the injury or death,
2. transfer to us their right to recover from others who may be responsible for their injury or death,
3. cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits paid fail to do these things, our duty to reimburse ends at once. If they claim damages from us for the injury or death, our duty to reimburse ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we reimbursed. We will pay the balance to the persons entitled to it. If persons entitled to the benefits make a recovery from others, they must repay us for the amounts that we have reimbursed you.

F. Reimbursement for Actual Loss Sustained

This endorsement provides only for reimbursement for the loss you actually sustain. In order for you to recover loss or expenses under this reimbursement you must:

1. actually sustain and pay the loss or expense in money after trial, or
2. secure our consent for the payment of the loss or expense.

G. Repatriation

Our reimbursement includes the additional expenses of repatriation to the United States of America necessarily incurred as a direct result of bodily injury.

Our reimbursement shall be limited as follows:

1. to the amount by which such expenses exceed the normal cost of returning the officer or employee if in good health, or
2. in the event of death, to the amount by which such expenses exceed the normal cost of returning the officer or employee if alive and in good health.

In no event shall our reimbursement exceed the bodily injury by accident limit shown in Item 3.B. of the Information Page as respects any one such officer or employee whether dead or alive.

H. Endemic Disease

The word "disease" includes any endemic diseases.

The coverage applies as if endemic diseases were included in the provisions of the workers' compensation law.

5. Longshore and Harbor Workers' Compensation Act Coverage

General Section C. Workers' Compensation Law is replaced by the following:

C. Workers' Compensation Law

Workers' Compensation Law means the workers or workers' compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workers' compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

Part Two (Employers' Liability Insurance), C. Exclusions, exclusion 8, does not apply to work subject to the Longshore and Harbor Workers' Compensation Act.

This coverage does not apply to work subject to the Defense Base Act, the Outer Continental Shelf Lands Act, or the Nonappropriated Fund Instrumentalities Act.

SECTION III

1. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval

C. Schedule of Covered States:

CA

Countersigned by _____

Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00.
Section II of this endorsement provides additional coverage usually only provided by endorsement.
Section III of this endorsement is a Schedule of Covered States.
You may use the index to locate these coverage features quickly:

INDEX

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PARTS ONE and TWO

1. WE WILL ALSO PAY

D. We Will Also Pay of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** of **Part 3** (Other States Insurance) is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Cancellation

Paragraph **2.** of **D. Cancellation** of **Part 6** (Conditions) is replaced by the following:

2. We may cancel this policy for non-payment of premium. We must mail or deliver to you not less than **15** business days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

5. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

6. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.

4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of the officer's or employee's employment. The officer's or 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

7. Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota, Ohio, Washington and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief that an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

SECTION III

8. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

PA

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDMENT TO EMPLOYERS' LIABILITY STOP GAP COVERAGE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement replaces III. Part Two, Section C Exclusions, 5. of the Employers' Liability Stop Gap Coverage Endorsement as follows:

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you.

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDMENT TO WORKERS' COMPENSATION BROAD FORM ENDORSEMENT EXTENDED OPTIONS - EMPLOYERS' LIABILITY STOP GAP COVERAGE

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement changes the Workers' Compensation Broad Form Endorsement Extended Options – Employers' Liability Stop Gap Coverage

6. Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota, Ohio, Washington, and Wyoming.

E. This paragraph is removed.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDMENT TO WORKERS' COMPENSATION BROAD FORM ENDORSEMENT- EMPLOYERS' LIABILITY STOP GAP COVERAGE

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement changes the Workers' Compensation Broad Form Endorsement – Employers' Liability Stop Gap Coverage

6. Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota, Ohio, Washington, and Wyoming

E. This paragraph is removed.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDMENT TO WORKERS' COMPENSATION BROAD FORM ENDORSEMENT- EMPLOYERS' LIABILITY STOP GAP COVERAGE

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement changes the Workers' Compensation Broad Form Endorsement – Employers' Liability Stop Gap Coverage

7. Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota, Ohio, Washington, and Wyoming.

E. This paragraph is removed.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

VIRGINIA COUNTERSIGNATURE EXCLUSION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

This endorsement applies only to the insurance provided by the policy because Virginia is shown in Item 3A of the Information Page.
Pursuant to Virginia Code §38.2-323, the following wording, as may be contained in this policy, does not apply in Virginia:

"This policy is not binding unless countersigned by our authorized representative."

"This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement."

Countersigned by _____
Authorized Representative

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ARIZONA COUNTERSIGNATURE EXCLUSION ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

The following wording, as may be contained in this policy, does not apply in Arizona:

"This policy is not binding unless countersigned by our authorized representative."

"This endorsement shall not be binding unless countersigned by a duly authorized agent of the company, provided that if this endorsement takes effect as of the effective date of the policy and, at issue of said policy, forms a part thereof, countersigned on the Information Page of said policy by a duly authorized Agent of the company shall constitute valid countersignature of this endorsement."

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

CALIFORNIA INSTALLMENT FEE DISCLOSURE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

A service fee of $7.00 is charged for each installment when your premium is paid in installments. The service fee is $5.00 per withdrawal when you select an electronic fund transfer payment plan. The service fee will be added to the premium amount shown on your premium billing statement.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WORKERS' COMPENSATION BROAD FORM ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Section I of this endorsement expands coverage provided under WC 00 00 00.
Section II of this endorsement provides additional coverage usually only provided by endorsement.
Section III of this endorsement is a Schedule of Covered States.
You may use the index to locate these coverage features quickly:

INDEX

SECTION I

PARTS ONE and TWO

1. WE WILL ALSO PAY

D. We Will Also Pay of **Part One** (WORKERS' COMPENSATION INSURANCE); and

E. We Will Also Pay of **Part Two** (EMPLOYERS' LIABILITY INSURANCE) is replaced by the following:

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, **INCLUDING** 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 law; and
5. expenses we incur.

PART THREE

2. How This Insurance Applies

Paragraph **4.** of **A. How This Insurance Applies** is replaced by the following:

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 **sixty** days.

PART SIX

3. Transfer Of Your Rights and Duties

C. Transfer Of Your Rights and Duties of **Part 6** (Conditions) is replaced by the following:

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

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

4. Liberalization

If we adopt a change in this form that would broaden the coverage of this form without extra charge, the broader coverage will apply to this policy. It will apply when the change becomes effective in your state.

SECTION II

VOLUNTARY COMPENSATION AND EMPLOYERS' LIABILITY COVERAGE

5. Voluntary Compensation Insurance

A. How This Insurance Applies

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

1. The bodily injury must be sustained by any officer or employee not subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page.
2. The bodily injury must arise out of and in the course of employment or incidental to work in a state shown in Item 3.A. of the Information Page.
3. The bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen, or otherwise legal resident, and legally employed, in the United States or Canada and temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of the officer's or employee's employment.

The officer's or 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 an amount equal to the benefits that would be required of you as if you and your employees were subject to the workers' compensation law of any state shown in Item 3.A. of the Information Page. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusion

This insurance does not cover:

1. any obligation imposed by workers' compensation or occupational disease law or any similar law.
2. bodily injury intentionally caused or aggravated by you.
3. officers or employees who have elected not to be subject to the state workers' compensation law.
4. partners or sole proprietors not covered under the Standard Sole Proprietors, Partners, Officers and Others Coverage Endorsement.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers' Liability Insurance

Part Two (Employers' Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment was shown in Item 3.A. of the Information Page.

This provision 5. does not apply in New Jersey or Wisconsin.

EMPLOYERS' LIABILITY STOP GAP COVERAGE

6. Employers' Liability Stop Gap Coverage

A. This coverage only applies in North Dakota, Ohio, Washington and Wyoming.

B. Part One (Workers' Compensation Insurance) does not apply to work in states shown in Paragraph A above.

C. Part Two (Employers' Liability Insurance) applies in the states, shown in Paragraph A., as though they were shown in Item 3.A. of the Information Page.

D. Part Two, Section C. **Exclusions** is changed by adding these exclusions.

This insurance does not cover;

5. bodily injury intentionally caused or aggravated by you or in Ohio bodily injury resulting from an act which is determined by an Ohio court of law to have been committed by you with the belief that an injury is substantially certain to occur. However, the cost of defending such claims or suits in Ohio is covered.
13. bodily injury sustained by any member of the flying crew of any aircraft.
14. any claim for bodily injury with respect to which you are deprived of any defense or defenses or are otherwise subject to penalty because of default in premium under the provisions of the workers' compensation law or laws of a state shown in Paragraph A.

SECTION III

7. SCHEDULE OF COVERED STATES

A. This endorsement only applies in the states listed in this Schedule of Covered States.

B. If a state, shown in Item 3.A. of the Information Page, approves this endorsement after the effective date of this policy, this endorsement will apply to this policy. The coverage will apply in the new state on the effective date of the state approval.

C. Schedule of Covered States:

IL

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GOODS AND SERVICES ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of Insurer: Twin City Fire Insurance Company

This endorsement modifies insurance provided under all Coverage Parts of this Policy.

We may offer or make "goods or services" available to you through this underwriting company, a non-insurer subsidiary, or unaffiliated third parties as a part of this policy. The "goods or services" may be provided for a charge, at a discount, on a subsidized basis, or free of charge. In some cases, we may receive a fee from the unaffiliated third parties that provide "goods or services". We do not warrant or guarantee the "goods or services" provided by third parties, and such third parties shall be solely liable and responsible for the "goods or services" they provide. The "goods or services" offered or made available by us may be modified or discontinued at any time.

"Goods or services" means goods, products or services, including but not limited to risk mitigation, safety, and/or loss prevention services or equipment.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GOODS AND SERVICES ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of Insurer: Hartford Underwriters Insurance Company

We may offer or make "goods or services" available to you through this underwriting company, a non-insurer subsidiary, or unaffiliated third parties as a part of this policy. The "goods or services" are optional and may be provided for a charge, at a discount, on a subsidized basis, or free of charge. In some cases, we may receive a fee from the unaffiliated third parties that provide "goods or services". We do not warrant or guarantee the "goods or services" provided by third parties, and such third parties shall be solely liable and responsible for the "goods or services" they provide. The "goods or services" offered or made available by us may be modified or discontinued at any time.

"Goods or services" means risk mitigation, safety, and/or loss prevention goods, products, services or equipment.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

GOODS AND SERVICES ENDORSEMENT WASHINGTON

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of Insurer: Twin City Fire Insurance Company

This endorsement modifies insurance provided under all Coverage Parts of this Policy.

We may offer or make "goods or services" available to you through this underwriting company, a non-insurer subsidiary, or unaffiliated third parties as a part of this policy. The "goods or services" may be provided for a charge, at a discount, on a subsidized basis, or free of charge. In some cases, we may receive a fee from the unaffiliated third parties that provide "goods or services". We do not warrant or guarantee the "goods or services" provided by third parties, and such third parties shall be solely liable and responsible for the "goods or services" they provide. The "goods or services" offered or made available by us may be modified or discontinued at any time.

This endorsement is subject to RCW 48.30.150(1)(c), which prohibits insurance companies from providing prizes, goods, wares, gift cards, gift certificates, or merchandise of an aggregate value in excess of $100 per person in the aggregate in any consecutive twelve-month period.

"Goods or services" means goods, products or services, including but not limited to risk mitigation, safety, and/or loss prevention services or equipment.

MAINTAINING YOUR RECORDS FOR AUDIT PURPOSES

WHAT IS A PREMIUM ADJUSTMENT?

When your Workers' Compensation policy was issued you paid a deposit premium based on the nature of your business and estimates of your payroll. At the end of the policy period, we conduct an audit to compare the estimates against the actual figures and operations. Based on this comparison an adjustment is made. If the actual premium is less than what you already have paid, a refund will be made. If it's more, you will be billed for the difference. These adjustments are subject to any minimum premiums that apply.

HOW WILL THE PREMIUM ADJUSTMENT BE MADE?

On smaller, less complex operations we may e-mail you, call you, or mail you a request to ask you to provide the information via our online web-based portal, mail or telephone. If we require this information, we will provide an electronic link to, or a paper copy of, the necessary forms for you to complete.

On larger, more complex operations one of our Premium Auditors will contact you for an appointment. You will be contacted either by e-mail, telephone or mail. If directed, the auditor will contact your accountant to obtain as much information as possible and contact you at a later time for additional information that may be needed.

BASIS OF PREMIUM

Remuneration (Payroll) in most states, includes:

Payment of:	Wages, bonuses, commissions, overtime,* sick pay, vacation pay,* tool allowances, contributions to individual retirement accounts, employee contributions to employee benefit plans.
Payments on basis of:	Piece work, incentive plans, profit sharing.
The value of:	Housing furnished to employees,* meals furnished to employees,* store certificates, merchandise and other dollar substitutes.

Remuneration does not include:

a. Employer contributions to a group insurance or pension plan other than statutory plans of insurance.
b. Special awards for individual inventions or discoveries.
c. Overtime.*

Subcontractors. In the absence of other insurance, most state laws hold a contractor responsible for injuries to employees of subcontractors. At the time of audit Certificates of Insurance must be available for subcontractors with employees, in order to avoid payment of premium.

Independent Contractors, without employees, whose duties closely resemble those of an employee, will be considered your employee with the appropriate premium charged.

The actual working relationship between you and the Independent Contractor is examined. Items such as, but not limited to: whether the work performed is an integral part of your operations, whether you have the right to control the details of the work, the method of payment, who supplied the materials used, does the person regularly work for others, whose regulatory authority did person operate under, whether the person is involved in a separate and distinct business offering the same services to the public.

RECORDS

As part of the policy conditions, we are allowed to examine your financial books and records to determine actual exposures and operations. We would appreciate your cooperation in making the needed records available for the auditor's inspection.

What Records Will Be Needed?

The records needed will vary. In most cases, the Premium Auditor will be able to obtain the necessary audit data from two or more of the following records: Journals, Ledgers, State and Federal Tax Reports, Individual Earning Cards, Checkbooks and Contracts.

How You Should Keep Your Records
By maintaining your payroll records in accordance with the following guidelines, you might reduce your insurance costs.

Overtime. In most states, the amount paid in excess of straight time pay can be deducted if it can be verified in your records. You must maintain your records to show pay separately by employee and in summary by classification of work.

***Division of an employee's payroll** to more than one classification is not allowed in most states.

Exception: For construction, erection or stevedoring operations the payroll of an employee may be allocated to each type of work performed if proper records are kept. Your records must show the number of hours and amount of payroll for each type of work. If you do not keep such a breakdown, the full salary must be charged to the highest rated classification to which the employee is exposed.

Executive Officers in most states are considered employees of their corporation and included in the computation of premium. Their remuneration is assigned without division to the actual operation in which they are engaged. If their duties are the same as those of a worker, foreman or superintendent, their payroll is assigned to the classification that develops the highest payroll. Minimum and maximum payrolls apply to executive officers.

Automated Records. If your records are automated or you plan to automate in the near future you can obtain maximum benefits by setting up your records to include insurance requirements. Our Premium Auditor will be pleased to assist you in setting up your records. Contact your Hartford Representative if you would like this assistance.

NOTE: The contents of this publication are not intended to supersede any definitions or conditions of your policy, the Workers' Compensation Law or any legal rulings.

**Your state may have specific rules or exceptions. Please contact your Hartford Representative for details that may apply and answer questions you may have.*

Customer Privacy Notice
The Hartford Financial Services Group, Inc. and Affiliates*
(herein called "we, our, and us")

This Privacy Policy applies to our United States Operations

We value your trust. We are committed to the responsible:

a) management;
b) use; and
c) protection;

of **Personal Information**.

This notice describes how we collect, disclose, and protect **Personal Information**.

We collect **Personal Information** to:

a) service your **Transactions** with us; and
b) support our business functions.

We may obtain **Personal Information** from:

a) **You**;
b) your **Transactions** with us; and
c) third parties such as a consumer-reporting agency.

Based on the type of product or service **You** apply for or get from us, **Personal Information** such as:

a) your name;
b) your address;
c) your income;
d) your payment; or
e) your credit history;

may be gathered from sources such as applications, **Transactions**, and consumer reports.

To serve **You** and service our business, we may share certain **Personal Information**. We will share **Personal Information**, only as allowed by law, with affiliates such as:

a) our insurance companies;
b) our employee agents;
c) our brokerage firms; and
d) our administrators.

As allowed by law, we may share **Personal Financial Information** with our affiliates to:

a) market our products; or
b) market our services;

to **You** without providing **You** with an option to prevent these disclosures.

We may also share **Personal Information**, only as allowed by law, with unaffiliated third parties including:

a) independent agents;
b) brokerage firms;
c) insurance companies;
d) administrators; and
e) service providers;

who help us serve **You** and service our business.

When allowed by law, we may share certain **Personal Financial Information** with other unaffiliated third parties who assist us by performing services or functions such as:

a) taking surveys;
b) marketing our products or services; or
c) offering financial products or services under a joint agreement between us and one or more financial institutions.

We, and third parties we partner with, may track some of the pages **You** visit through the use of:

a) cookies;
b) pixel tagging; or
c) other technologies;

and currently do not process or comply with any web browser's "do not track" signal or other similar mechanism that indicates a request to disable online tracking of individual users who visit our websites or use our services.

For more information, our Online Privacy Policy, which governs information we collect on our website and our affiliate websites, is available at https://www.thehartford.com/online-privacy-policy.

We will not sell or share your **Personal Financial Information** with anyone for purposes unrelated to our business functions without offering **You** the opportunity to:

a) "opt-out;" or
b) "opt-in;"

as required by law.

We only disclose **Personal Health Information** with:

a) your authorization; or
b) as otherwise allowed or required by law.

Our employees have access to **Personal Information** in the course of doing their jobs, such as:

a) underwriting policies;
b) paying claims;
c) developing new products; or
d) advising customers of our products and services.

We use manual and electronic security procedures to maintain:

a) the confidentiality; and
b) the integrity of;

Personal Information that we have. We use these procedures to guard against unauthorized access.

Some techniques we use to protect **Personal Information** include:

a) secured files;
b) user authentication;
c) encryption;
d) firewall technology; and
e) the use of detection software.

We are responsible for and must:

a) identify information to be protected;
b) provide an adequate level of protection for that data; and
c) grant access to protected data only to those people who must use it in the performance of their job-related duties.

Employees who violate our privacy policies and procedures may be subject to discipline, which may include termination of their employment with us.

We will continue to follow our Privacy Policy regarding **Personal Information** even when a business relationship no longer exists between us.

As used in this Privacy Notice:

Application means your request for our product or service.

Personal Financial Information means financial information such as:

a) credit history;
b) income;
c) financial benefits; or
d) policy or claim information.

Personal Financial Information may include Social Security Numbers, Driver's license numbers, or other government-issued identification numbers, or credit, debit card, or bank account numbers.

Personal Health Information means health information such as:

a) your medical records; or
b) information about your illness, disability or injury.

Personal Information means information that identifies **You** personally and is not otherwise available to the public. It includes:

a) **Personal Financial Information**; and
b) **Personal Health Information**.

Transaction means your business dealings with us, such as:

a) your **Application**;
b) your request for us to pay a claim; and
c) your request for us to take an action on your account.

You means an individual who has given us **Personal Information** in conjunction with:

a) asking about;
b) applying for; or
c) obtaining;

a financial product or service from us if the product or service is used mainly for personal, family, or household purposes.

If you have any questions or comments about this privacy notice, please feel free to contact us at The Hartford - Consumer Rights and Privacy Compliance Unit, One Hartford Plaza, Mail Drop: HO1-09, Hartford, CT 06155, or at ConsumerPrivacyInquiriesMailbox@thehartford.com.

This Customer Privacy Notice is being provided on behalf of The Hartford Financial Services Group, Inc. and its affiliates (including the following as of February 2022), to the extent required by the Gramm-Leach-Bliley Act and implementing regulations:

1stAGChoice, Inc.; Access CoverageCorp, Inc.; Access CoverageCorp Technologies, Inc.; Business Management Group, Inc.; Cervus Claim Solutions, LLC; First State Insurance Company; FTC Resolution Company LLC; Hart Re Group L.L.C.; Hartford Accident and Indemnity Company; Hartford Administrative Services Company; Hartford Casualty General Agency, Inc.; Hartford Casualty Insurance Company; Hartford Fire General Agency, Inc.; Hartford Fire Insurance Company; Hartford Funds Distributors, LLC; Hartford Funds Management Company, LLC; Hartford Funds Management Group, Inc.; Hartford Holdings, Inc.; Hartford Insurance Company of Illinois; Hartford Insurance Company of the Midwest; Hartford Insurance Company of the Southeast; Hartford Insurance, Ltd.; Hartford Integrated Technologies, Inc.; Hartford Investment Management Company; Hartford Life and Accident Insurance Company; Hartford Lloyd's Corporation; Hartford Lloyd's Insurance Company; Hartford Management, Ltd.; Hartford Productivity Services LLC; Hartford of the Southeast General Agency, Inc.; Hartford of Texas General Agency, Inc.; Hartford Residual Market, L.C.C.; Hartford Specialty Insurance Services of Texas, LLC; Hartford STAG Ventures LLC; Hartford Strategic Investments, LLC; Hartford Underwriters General Agency, Inc.; Hartford Underwriters Insurance Company; Heritage Holdings, Inc.; Heritage Reinsurance Company, Ltd.; HLA LLC; HL Investment Advisors, LLC; Horizon Management Group, LLC; HRA Brokerage Services, Inc.; Lattice Strategies LLC; Maxum Casualty Insurance Company; Maxum Indemnity Company; Maxum Specialty Services Corporation; Millennium Underwriting Limited; MPC Resolution Company LLC; Navigators (Asia) Limited; Navigators Corporate Underwriters Limited; Navigators Holdings (UK) Limited; Navigators Insurance Company; Navigators International Insurance Company Ltd.; Navigators Management Company, Inc.; Navigators Management (UK) Limited; Navigators N.V.; Navigators Specialty Insurance Company; Navigators Underwriting Agency Limited; Navigators Underwriting Limited; New England Insurance Company; New England Reinsurance Corporation; New Ocean Insurance Co., Ltd.; NIC Investments (Chile) SpA; Nutmeg Insurance Agency, Inc.; Nutmeg Insurance Company; Pacific Insurance Company, Limited; Property and Casualty Insurance Company of Hartford; Sentinel Insurance Company, Ltd.; The Navigators Group, Inc.; Trumbull Flood Management, L.L.C.; Trumbull Insurance Company; Twin City Fire Insurance Company; Y-Risk, LLC.

POLICYHOLDER NOTICE

PAYROLL RECORD AND AUDIT REQUIREMENTS FOR DUAL WAGE CONSTRUCTION OR ERECTION CLASSIFICATIONS

Your policy includes one or more construction or erection classifications. Dual wage classifications are pairs of classifications that describe the same construction or erection operation yet are assigned based upon whether the employee's hourly wage is above or below a specified threshold. Each pair of dual wage classifications contains one "high wage" classification that is assignable to payrolls earned by employees whose regular hourly wage equals or exceeds a specified wage threshold and one "low wage" classification that is assignable to payrolls earned by employees whose regular hourly wage is less than the specified threshold.

Payroll Record Requirements

The assignment of a high wage classification is contingent on verifying that the employee's hourly wage equals or exceeds the specified wage threshold. The determination of the regular hourly wage for any non-salaried employee must be supported by one of the following sources:

- Original time cards or time book entries for each employee. Original records must include the operations performed, the total hours worked each day and the times the employee started and ended each work period throughout the workday. At job locations where all of the employer's operations cease for a uniform unpaid meal period, recording the start and stop times of the uniform break period is not required.

- A valid collective bargaining agreement that shows the regular hourly wage rate by job classification of a worker. If using a collective bargaining agreement, the records must include an employee roster by job classification that permits the reconciliation of individual employees to the job classifications set forth in the collective bargaining agreement.

The non-salaried employee's regular hourly wage shall be determined by dividing that employee's total remuneration by the hours worked during the pay period, irrespective of whether the employee is paid on an hourly, piecework, production or commission basis.

The payroll earned by any non-salaried employees for whom the records specified above are not maintained and/or made available will be assigned to the low wage classification that describes the operations performed.

The regular hourly wage of salaried employees is determined by dividing the total annual remuneration by 2000 hours. If an employee is salaried for less than 12 months, the regular hourly wage for the salaried period is calculated on a prorated basis.

Audit Requirements

If your policy has an effective date on or after January 1, 2020 and produces a final premium of $10,500 or more, a physical audit is required at least once a year; if it produces a final premium of less than $10,500 and develops payroll in a high wage classification, a physical audit of the policy is required unless the policy is a renewal and a physical audit was completed for one of the two immediately preceding policy periods. A "physical audit" is defined as an audit of payroll, whether conducted at the policyholder's location or at a remote site, that is based upon an auditor's examination of the policyholder's books of accounts and original payroll records (in either electronic or hard copy form) as necessary to determine and verify the exposure amounts by classification.

If you hold a C-39 Roofing Contractor license from the California Contractors State License Board, a physical audit is required on the complete policy period of each policy regardless of the amount of final premium. See California Insurance Code Section 11665(a) for additional requirements regarding the audit of C-39 license holders.

Form PN 04 99 06 D Printed in U.S.A.

POLICYHOLDER NOTICE OF SHORT RATE CANCELLATION PROVISIONS

If the policy is cancelled by the insured before the end of the policy term, except if the reason for cancellation is permanent closure or sale of the business, The Hartford will apply a short rate cancellation fee. This means that the final premium will be more than pro rata, as it will be increased by a short rate cancellation fee. The amount of the fee will vary depending on how early the policy is cancelled or whether your policy is subject to an annual minimum premium. The range of the fee is 5% to 100% of the full premium, and the final premium will not be less than the minimum premium. The method for determining the short rate cancellation fee can vary by state; contact your agent or broker if more information is required. (Note: the Short Rate Cancellation rules do not apply in the state of TX.)

$2,300 MEDICAL SERVICE DEDUCTIBLE

Oregon Administration Rule 436-060-0055 requires insurers to notify employers of their right to pay, through reimbursement, up to $2,300 in medical costs for each non-disabling workers' compensation claim, and of the responsibilities of employers and insurers under this plan. Please note that:

1. Employers are responsible for promptly reporting all claims.
2. Insurers are responsible for determining compensability, for auditing medical charges, for timely processing, and **for actual payment of all claims.**

IF YOU WISH TO PARTICIPATE

You must notify us in writing within 30 days of receiving this notice. If you do not respond, you are presumed to reject participation.

An election to participate remains in effect until you withdraw it by written notice.

IF YOU NOTIFY US YOU WISH TO PARTICIPATE

Within 30 days after the end of each month, we will send you a list of eligible claims.

Within 30 days after you receive the list, you must identify the claims and dollar amounts you want to pay, and reimburse us.

Your failure to reimburse us within 30 days will be deemed notice that you do not wish to participate for that period.

Any amounts you reimburse us will not be included in the calculation of your future experience modifiers.

WHAT EFFECT WILL IT HAVE?

You should be aware that this plan will not affect your experience rating for a minimum of two years. The effect on your experience rating may or may not offset your out-of-pocket costs.

If you are on a retrospective rating plan, the employer-paid costs **will** be included in the retrospective premium computation, **but** these amounts will be subsequently credited against the resulting retrospective premium.

Form WC 66 00 97 I Printed in U.S.A.

PRODUCER COMPENSATION NOTICE

You can review and obtain information on The Hartford's producer compensation practices at www.TheHartford.com or at 1-800-592-5717.

POLICYHOLDER DISCLOSURE
NOTICE OF TERRORISM INSURANCE COVERAGE

Coverage for acts of terrorism is included in your policy. You are hereby notified that the Terrorism Risk Insurance Act, as amended in 2019, defines an act of terrorism in Section 102(1) of the Act: The term "act of terrorism" means any act or acts that are certified by the Secretary of the Treasury-in consultation with the Secretary of Homeland Security, and the Attorney General of the United States-to be an act of terrorism; to be a violent act or an act that is dangerous to human life, property, or infrastructure; to have resulted in damage within the United States, or outside the United States in the case of certain air carriers or vessels or the premises of a United States mission; and to have 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. Under your coverage, any losses resulting from certified acts of terrorism may be partially reimbursed by the United States Government under a formula established by the Terrorism Risk Insurance Act, as amended. However, your policy may contain other exclusions which might affect your coverage, such as an exclusion for nuclear events. Under the formula, the United States Government generally reimburses 80% beginning on January 1, 2020, of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The Terrorism Risk Insurance Act, as amended, contains a $100 billion cap that limits U.S. Government reimbursement as well as insurers' liability for losses resulting from certified acts of terrorism when the amount of such losses exceeds $100 billion in any one calendar year. If the aggregate insured losses for all insurers exceed $100 billion, your coverage may be reduced.

The portion of your annual premium that is attributable to coverage for acts of terrorism is $ 203 , and does not include any charges for the portion of losses covered by the United States government under the Act.

Name of Insurer: Hartford Underwriters Insurance Company

Policy Number: 08 WEC AP8931

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

Name of California Insurer:

This endorsement addresses the requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2019. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for losses that may occur in the event of an Act of Terrorism.

Your policy provides coverage for workers compensation losses caused by Acts of Terrorism, including workers compensation benefit obligations dictated by state law. Coverage for such losses is still subject to all terms, definitions, exclusions, and conditions in your policy, and any applicable federal and/or state laws, rules, or regulations.

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.

"Act" means the Terrorism Risk Insurance Act of 2002, which took effect on November 26, 2002, and any amendments thereto, including any amendments resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2019.

"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.

"Insured Loss" means any loss resulting from an act of terrorism (and, except for Pennsylvania, 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.

"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 limits 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 are not 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 will pay only 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 will not make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.
3. The premium charge for the coverage your policy provides for Insured Losses is included in the amount shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate	Premium
See Attached Schedule		

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

Policy Number: 08 WEC AP8931 **Endorsement Number:**
Effective Date: 08/11/22 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: CAMUNDA INC
275 BATTERY ST STE 2600
SAN FRANCISCO CA 94111

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

Schedule

Rate per $100 of Remuneration

NOTICE TO INDIANA POLICYHOLDERS

We are here to serve you . . .

As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied . . .

Should you feel you are not being treated fairly, we want you to know you may contact the Indiana Department of Insurance with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

Public Information/Market Conduct
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: 1-800-622-4461

In the Indianapolis
Area: 1-317-232-2395

The HARTFORD

Form G-3067-0 Printed in U.S.A.

WISCONSIN NOTICE OF RIGHT TO FILE A COMPLAINT

KEEP THIS WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

THE HARTFORD
BUSINESS SERVICE CENTER
3600 WISEMAN BLVD
SAN ANTONIO TX 78251
(866) 467-8730

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P. O. Box 7873
Madison, WI 53707-7873

or you can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

Form G-3143-0 Printed in U.S.A.

Process Date: 07/02/22 **Expiration Date:** 08/11/23

NEVADA NOTICE TO POLICYHOLDERS

In accordance with Chapter 680B of the Nevada Revised Statutes, each renewal must include information on taxes, fees, and assessments included in the premium you are required to pay.

A portion of the premium for this policy is attributable to the general premium tax we are required to pay to the State of Nevada pursuant to Section 680B.027 of the Nevada Revised Statutes.

A portion of the premium for this policy is also attributable to annual fees or assessments we are required to pay to the State of Nevada.

ARIZONA NOTICE
INDEPENDENT CONTRACTORS

Section 23-902 of the Arizona statutes states that a contractor is deemed an employee of the "employer" for which they are working if:

- The employer retains supervision or control over the contractor

and

- The work is ongoing, regular, ordinary, or routine in your operation and is routinely done by your own employees

If the above conditions are met, we will treat the contractor as an employee and make the appropriate premium charge.

Section 23-964, Section L of the Arizona statutes allows a contractor who is a sole proprietor to waive rights to Workers Compensation coverage. No additional premium charge will be made, if the sole proprietor completes form WC 66 02 35 "Arizona Sole Proprietor Waiver".

For further information, please contact your agent or broker.

CALIFORNIA NOTICE

CALIFORNIA LABOR CODE 3551 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS CODE, EXCEPT EMPLOYERS OF EMPLOYEES DEFINED IN SUBDIVISION (d) OF SECTION 3351, SHALL GIVE EVERY NEW EMPLOYEE, EITHER AT THE TIME OF HIRE, OR BY THE END OF THE FIRST PAY PERIOD, WRITTEN NOTICE OF THE INFORMATION CONTAINED IN SECTION 3550.

CALIFORNIA LABOR CODE 3550 PROVIDES THAT EVERY EMPLOYER SUBJECT TO THE COMPENSATION PROVISIONS OF THIS DIVISION SHALL POST AND KEEP POSTED IN A CONSPICUOUS LOCATION FREQUENTED BY EMPLOYEES, AND WHERE THE NOTICE MAY BE EASILY READ BY EMPLOYEES DURING THE HOURS OF THE WORKDAY, A NOTICE WHICH SHALL STATE THE NAME OF THE CURRENT COMPENSATION INSURANCE CARRIER OF THE EMPLOYER, OR WHEN SUCH IS THE FACT, THAT THE EMPLOYER IS SELF-INSURED, AND WHO IS RESPONSIBLE FOR CLAIMS ADJUSTMENT.

LOUISIANA WORKER'S COMPENSATION
SECOND INJURY FUND

Louisiana established a Second Injury Fund effective July 31, 1977. The purpose for establishing this Fund is to encourage the employment of physically handicapped employees who have a permanent, partial disability by protecting employers and insurers from excess liability for Worker's Compensation for disability. Effective October 1, 1977, the employer is entitled to reimbursement from the Fund if the subsequent injury would not have occurred without the pre-existing injury, or if subsequent injury results in disability greater than would have resulted from the subsequent injury alone.

Notice of Claim Against Second Injury Fund must be filed with the Second Injury Board within 52 weeks after the first payment of weekly compensation.

Form WC 66 00 53 A Printed in U.S.A.

An Introduction to Workers Compensation: Background for Oregon Employers

Introduction
In accordance with the intent of the Oregon law, this booklet was prepared for voluntary distribution to Oregon employers by the insurance industry. In it, you will find answers to basic questions about workers compensation insurance.

National Council on Compensation Insurance (NCCI)
The National Council on Compensation Insurance is a voluntary, non-profit, statistical, research and ratemaking organization licensed under Oregon Revised Statutes 737.350. Supported by the insurance industry, NCCI's primary functions are the preparation and administration of rates, rating plans, and systems for workers compensation insurance. In Oregon, NCCI prepares a schedule of rates for insureds in the assigned risk plan, subject to insurance department approval, and acts in an advisory capacity for insurers writing the remainder of the business in the state.

As the rating organization, it is NCCI's obligation to collect payroll and loss information, by individual classification, for each workers compensation insurance policy in the state of Oregon. In addition, the rating organization will perform inspections at employers' premises to determine the proper classifications, perform test audits, promulgate experience rating modifications, and administer the Workers Compensation Insurance Plan (WCIP) for those employers unable to obtain coverage voluntarily.

Workers Compensation Rates
NCCI uses the collected payroll and loss data to actuarially determine that portion of each individual classification rate necessary to pay the losses. This amount is called the pure premium. Oregon insurers may use the pure premiums determined by NCCI, or may derive their own pure premium when preparing their rates. Each carrier applies its own "factor" to provide for the additional costs of taxes, licenses, fees, acquisition and field supervision, and other company expenses. This "factored" rate is the amount charged per $100 of payroll.

Classifications
There are approximately 500 different workers compensation classifications, each of which individually describes a particular occupation. Generally, each employer will be entitled to the ONE basic classification which most accurately describes its operations. In addition, when that one basic classification does not specifically include one of the "Standard Exception" classifications (Clerical, Outside Salespersons, or Drivers), each employer may also be entitled to three additional classifications: Code 7380 - Drivers, Chauffeurs & Helpers; Code 8742 - Salespersons, Collectors or Messengers - Outside; and Code 8810 - Clerical Office Employees. Your insurance carrier will advise you of the classifications applicable to your operations.

However, when an employer is engaged in Construction, Erection, Stevedoring, Aircraft Operations (Industrial Aid), or Trucking as a secondary business, additional classifications may be assigned. Again, your carrier will counsel you on the classifications applicable to your operations.

Division of Individual Employee's Payroll
When any employee performs different duties which, if performed by a different worker, would qualify for a different classification assignment, you may divide that person's payroll between two or more classifications, PROVIDED separate verifiable payroll records are adequately maintained. When verifiable payroll records are not maintained, that individual's payroll must be assigned to the highest-rated classification for any of the duties performed.

Verifiable Records
Payroll records of an employee are verifiable if they have the following characteristics: (a) The records must establish a time basis, and the time basis must be hourly or a part thereof, daily or part thereof, weekly or part thereof, monthly or part thereof or yearly or part thereof; (b) For each salaried employee, the records must also include time records in which the salary is converted to an hourly, daily, weekly, monthly or yearly rate and then multiplied by the time spent by the employee in each classification exposure; (c) The records must include a description of duties performed by the employee, to enable the insurer to determine correct classification assignment. Records requiring additional explanation or interpretation are not considered to be verifiable; and (d) The records must be supported by original entries from other records, including but not limited to time cards, calendars, planners or daily logs prepared by the employee or the employee's direct supervisor or manager. Estimated ratios or percentages of time spent performing the different duties are not acceptable for verification. Verifiable records must be summarized in the employer's accounting records.

Remuneration - Payroll
'Payroll' means the TOTAL remuneration paid or payable by the employer for the services of the employees covered by the policy. Payroll INCLUDES commissions, anticipated bonuses, straight hourly wages for all hours worked, holiday pay, sick pay, piecework pay, tool allowances, value of living quarters provided by the employer, value of meals provided, value of store certificates or merchandise provided, and credits or any

other substitute for money received by employees. Payroll does NOT INCLUDE profit-sharing amounts, unanticipated bonuses, vacation pay, tips or other gratuities received by employees from others, payments by the employer to group insurance or group pension plans, value of special rewards for individual invention or discovery, the value of a company-provided vehicle which is used in the employer's business, or dismissal or severance payments except for the pay earned for the time worked. It also excludes payments from a program to reward workers for safe working practices.

Subcontractors
When you subcontract a portion (or all) of your work to others and retain the right to exercise any direction and control (regardless of whether that right is exercised), you will be expected to pay the premiums for that subcontracted payroll UNLESS the subcontractor has its own workers compensation insurance coverage. In order to avoid the payment of premium for your subcontractors, you should obtain a CERTIFICATE OF INSURANCE from each subcontractor. At the time of audit, your insurance carrier will ask for any certificates of insurance and will exclude the subcontractor's payroll when the certificate is available.

Experience Rating
When any employer's initial policy develops an annual premium in excess of $5,000, the employer will qualify for experience rating at the beginning of the THIRD year and annually thereafter. When the employer develops premium in excess of $2,500 (but less than $5,000), they will qualify for an experience rating modification at the beginning of the FOURTH year. These qualifying premium amounts are subject to change.

Essentially, the Experience Rating Program will use your company's payroll, by individual classification, to determine the AVERAGE amount of losses expected to emerge from that payroll. It will then compare those EXPECTED LOSSES to the ACTUAL LOSSES which were paid and/or reserved for any injuries occurring during the period covered by the data used in the annual experience rating process. When your company has BETTER than average experience, the experience modification will result in a CREDIT (reduction in your final premium), but if your experience is WORSE than average, a DEBIT (surcharge) will apply.

Merit Rating
When an employer is too small to qualify for experience rating, a MERIT RATING program will apply. In general, this program will: a) reduce your final premium if there were no payments for "lost- time" injuries during the most recent year for which data has been compiled; b) will not affect your premium when there was only ONE lost-time injury; and c) will surcharge your premium when there are two or more lost-time injuries. Oregon law provides that, with the approval of regulatory authorities, insurance carriers may use their own customized merit rating plan. Maximum credits or surcharges are 10 percent. Check with your insurance carrier or agent for specific information about merit rating plans in effect in Oregon.

Federal Coverages
While most employees will be subject to only the Oregon Workers Compensation Act, others MAY be subject to the Admiralty Act (for masters or members of a vessel), to the Federal Employers Liability Act (railroads engaged in interstate commerce), or the Longshore and Harborworkers Compensation Act (for stevedoring operations, building or repairing of vessels, new construction work in connection with marinas, etc.). However, the determination of exposures under any of the Federal Acts is a legal question which should be discussed with your insurance carrier or agent.

Final Premium
When you obtain a policy from your insurance carrier, the premium will be ESTIMATED from the description of work and payroll information supplied by you. Your insurance carrier may either make interim audits or audit your account when your policy has expired. At that time, your final premium will be based upon the ACTUAL payrolls.

Oregon Classification and Rating Committee
A Committee, composed of members well-versed in workers compensation insurance matters, meets periodically to hear the grievances of employers who feel they have been treated improperly in the assignment of classifications, payroll assignments, or experience ratings. (Since the "rate" is an actuarial product which has been reviewed by the Insurance Department prior to approval for use, the appeal may NOT be based upon the rate for an individual classification.) Should you feel you have been aggrieved, you may direct your specific allegations to NCCI - Northwestern Service Office, One S.W. Columbia (Suite 850), Portland, OR 97258 or contact your carrier for further information.

Conclusion
The above information has been designed to provide you with a broad overview of the Oregon Workers Compensation Insurance system. Should you have further questions, please contact your carrier or NCCI-Northwestern Service Office at the address indicated above.

N O T I C E

The Information Page of your Workers Compensation and Employers Liability Insurance Policy contains line items for (1) a Second Injury Fund Surcharge and (2) an Uninsured Employer's Fund Surcharge. Each surcharge amount represents a percentage of your total estimated standard premium and will be subject to adjustment when the final audited standard premium is determined. Explanations of these surcharges are provided below.

SECOND INJURY FUND

The New Jersey Workers Compensation Law established the Second Injury Fund to provide benefits to workers who become permanently and totally disabled as a result of work-related injury or occupational disease when that worker had been previously partially disabled. The Law also requires that the Fund provide annual adjustments to certain persons permanently and totally disabled and to certain dependents of deceased workers.

Through 1988, the Second Injury Fund was financed by an annual assessment upon insurance carriers. Such assessment was included in your standard premium via the manual premium rate(s) shown in your policy Information Page.

Effective January 1, 1989, an amendment to the Law requires that the present financing be replaced by a direct surcharge shown as a separate "Second Injury Fund Surcharge" line on your policy Information Page. It will no longer be included in the manual premium rate. This new system will discourage other states from imposing retaliatory taxes on New Jersey based insurance companies and ultimately aid cost containment efforts.

UNINSURED EMPLOYERS FUND

The New Jersey Workers Compensation Law requires every employer to provide workers compensation coverage through purchase of a workers compensation and employers liability insurance policy. Failure to provide such coverage results in a fine and/or criminal action by the Department of Labor as well as continued liability for benefit payments to an injured worker.

The Uninsured Employers Fund was established by Law to provide benefits to an injured worker when the employer has failed to comply with the insurance provisions of the Law and is unable to provide the required benefits. Through 1988 total financing of the Fund was derived from fines imposed upon uninsured employers.

Effective January 1, 1989, an amendment to the Law requires that the present financing be supplemented by a direct surcharge shown as a separate "Uninsured Employers Fund Surcharge" line on your policy Information Page. This method will assure the delivery of benefits to injured workers and the surcharge will cease whenever the year end balance of the Fund exceeds $500,000.

TO OUR POLICYHOLDERS:

Colorado House Bill 1212 requires that companies providing Workers' Compensation Coverage in Colorado make available their risk management services in order that all insureds may establish a formal risk management program. If your company is interested in establishing such a program, please contact your independent agent and they will see to it that this material is provided to you.

TO OUR MINNESOTA INSUREDS

The Hartford has a program available that would allow you as an employer to pay small Workers' Compensation claims in return for a reduction in your premium. This is a deductible program in which we will continue to handle all claims for you, then bill you for the amount of the claim within the deductible. All claims within or above the deductible level will continue to be reported for the purposes of determining your experience modification if you qualify for that program.

Should you be interested in such a program please contact your Hartford agent for the details on how this program would effect your insurance program.

NOTICE TO POLICYHOLDER

CALIFORNIA WORKERS' COMPENSATION

INSURANCE RATING LAWS

Pursuant to Section 11752.8 of the California Insurance Code, we are providing you with an explanation of the California workers' compensation rating laws applicable to new and renewal policies with policy effective dates on and after January 1, 1995.

1. The laws requiring all insurers to charge the same minimum rate uniformly to all employers within a given classification has been repealed. Beginning January 1, 1995, we will establish our own rates for workers' compensation. Our rates will not be applicable prior to the first normal policy effective date of a policy incepting on or after January 1, 1995. Our rates, rating plans and related information are filed with the Insurance Commissioner and are open for public inspection.

2. The Insurance Commissioner can disapprove our rates, rating plans or classifications only if he has determined after public hearing that our rates might jeopardize our ability to pay claims or create a monopoly in the market. A monopoly is defined by law as a market where one insurer writes 20% or more of that part of the California workers' compensation insurance that is not written by the State Compensation Insurance Fund. If the insurance Commissioner disapproves our rates, rating plans or classification, he may order an increase in the rates applicable to outstanding policies.

3. Rating organizations may develop pure premium rates which are subject to the Insurance Commissioner's approval. A pure premium rate reflects the anticipated cost and expenses of claims per $100 of payroll for a given classification. Pure premium rates are advisory only, as we are not required to sue the pure premium rates developed by any rating organization in establishing our own rates.

4. We must adhere to a single, uniform experience rating plan. If you are eligible for experience rating under the plan, we will be required to adjust your premium to reflect your claim history. A better claim history generally results in a lower experience rating modification; more claims, or more expensive claims, generally result in a higher experience rating modification. The uniform experience rating plan developed by the insurance rating organization designated by the Insurance commissioner is subject to the approval of the Insurance Commissioner.

5. A standard classification system developed by the insurance rating organization designated by the Insurance Commissioner is subject to approval of the Insurance Commissioner. The standard classification system is a method of recognizing and separating policyholders into industry or occupational groups according to their similarities and/or differences. We can adopt and apply the standard classification system or develop and apply our own classification system, provided that we can report the payroll, expenses and other costs of claims in a way which is consistent with the standard classification system.

6. Our rates and classifications may not violate the Unruh Civil Rights Act or be unfairly discriminatory.

7. We will provide an appeal process for you to appeal the way we rate your insurance policy. The process will require us to respond to your written appeal within 30 days. If you are not satisfied with the result of your appeal, you may appeal our decision to the Insurance Commissioner.

We're protected by

WORKERS' COMPENSATION

Follow safety rules and *you'll* be protected from injury. But if you *are* injured at work, you're protected by benefits.

PREVENT THE ABUSE OF WORKERS' COMPENSATION CLAIMS

We Help Employers Fight Fraud

If you suspect a claim is fraudulent, or that it abuses the system, work with your insurance carrier to prepare evidence of the alleged fraud. Then Report the case to:

Workers' Compensation Fraud Unit
201 E. Washington Avenue
P.O. Box 7901
Madison, WI 53707-7901

For quick help, call the Fraud Hotline: (608) 261-8486

What We Can Do to Help

The Workers' Compensation Division is authorized by Wisconsin Statute 102.125 to work with employers and insurers to report, investigate, and prosecute allegations of Workers' Compensation fraud. Here's what we do:

- Work with you and your insurance carrier to determine if there is enough evidence to take the case to court.
- Refer the case to the local District Attorney's Office for prosecution if there is sufficient evidence of fraud. Cooperation from the Justice Department and District Attorneys has been excellent. They will prosecute!

PROVE IT!

Conviction of a fraudulent claim requires proof beyond a reasonable doubt of an intentional misrepresentation to secure benefits. Only the best-documented cases succeed.

Prevention Is the Best Defense

A well-designed loss control program and the serious threat of legal action are very effective deterrents to abusive claims.

Fraud Prevention Tips

1. Develop a first-class safety program. Claims are less likely to mushroom if injuries are prevented and employees feel that management is genuinely concerned about their safety. You can do that by establishing and practicing clear and comprehensive safety policies.
2. Establish strong accident investigation procedures. Injured employees and witnesses should be interviewed in person about the accident as soon as possible. Document all statements. Get a signed statement from the claimant.
3. Send the Supervisor with the injured worker to the medical provider. Show concern for getting first-class medical evaluations and treatments.
4. Establish procedures for a clear understanding of essential information. Make sure the treating physician understands the nature of the job. Make sure the supervisor understands return-to-work limitations.
5. Make sure employees understand that false claims can be punished by termination and criminal prosecution.

- **You don't need a lawyer to get benefits**
- **You won't get in trouble for reporting an injury or making a truthful claim.**

Report injuries to your supervisor immediately.

- **Your supervisor will help you start your claim.**
- **Don't make a Workers' Compensation claim unless it's legitimate. You risk jail, a fine or job loss.**

Call the Fraud Hotline if you know about a false claim, (608) 261-8486. Or you can reach the Fraud Unit on the World Wide Web at http://www.dwd.state.wi.us/wc. Save everyone the added insurance costs and a possible reduction in wage increases. Fraud hurts us all.

Form WC 66 02 72 Printed in U.S.A.

FLORIDA
DEPARTMENT OF
FINANCIAL SERVICES
Tom Gallagher, Chief Financial Officer

Division of Workers' Compensation

IMPORTANT WORKERS' COMPENSATION INFORMATION FOR CONTRACTORS

Coverage Requirements

1) A contractor or sub-contractor who is engaged in the construction industry and employs one or more employees must have Florida workers' compensation insurance. Corporate officers, in addition to limited liability company members, sole proprietors, partners, and independent contractors engaged in the construction industry are considered employees under Florida's workers' compensation law. However, a contractor or sub-contractor who is engaged in the construction industry and is a corporate officer or a member of a limited liability company can apply for and obtain a valid construction industry exemption. Workers' compensation insurance is still required for the contractor's or subcontractor's employees.
2) A contractor shall require any sub-contractor who sub-contracts work from a contractor to provide evidence of Florida workers' compensation insurance. If the sub-contractor has a valid exemption, then the subcontractor shall also provide a copy of his or her certificate of exemption to the contractor.
3) A change in job duties performed by employees or an increase in the amount of payroll of a business must be reported to the insurance company.
4) If a contractor has secured workers compensation coverage for his or her employees by entering into an employee leasing arrangement, the contractor must specifically identify coverage for each and every employee. The contractor must notify the employee leasing company of the names of all the covered employees and any additional employees that are working on a jobsite that may have been excluded from the employee leasing arrangement. Any change in job duties performed by the employees must also be reported to the employee leasing company.
5) Please see the reverse side of this flyer for information about obtaining worker's compensation insurance and for the eligibility requirements for a construction industry exemption.

Out-Of-State Contractors

1) An out-of-state contractor must immediately notify his or her insurance company and, or insurance agent that it has employees that are engaging in work in Florida.
2) An out-of-state construction industry contractor who has employees engaged in work in Florida, must either obtain a Florida workers' compensation insurance policy or an endorsement must be added to the out-of-state contractor's policy that lists Florida in section 3.A. of the policy.
3) A Florida construction contractor engaged in work in this state who contracts with out-of-state contractors, must require proof of a Florida workers' compensation policy or an endorsement to the out-of-state contractor's policy that lists Florida in section 3.A. of the policy. If the out-of-state subcontractor does not provide proof of a Florida workers' compensation policy or of an endorsement to the policy, or does not have a valid workers' compensation exemption; the Florida contractor must contact his or her workers' compensation insurance carrier to update his or her policy to include such sub-contractor and any persons that are employed by such sub-contractor.

Enforcement Provisions

1) The Florida Division of Workers' Compensation is responsible for enforcing employer compliance with the coverage requirements of the workers' compensation law. Compliance investigators have the authority to conduct on-site inspections of job sites to ensure employer compliance. Investigators can also request an employer's business records. An employer must produce the required business records within five business days of the division's written request for records. If the employer fails to respond to the request within five business days, the division will issue a stop work order upon the employer requiring the employer to cease all business operations in the state.

2) A stop work order will also be issued to any employer who is required to secure Florida workers' compensation coverage but fails to do so. A stop work order will also be issued in cases where an employer may have a workers' compensation policy but understates or conceals payroll, misrepresents or conceals employee duties or fails to utilize Florida's class codes and workers' compensation rates.

3) In order for the division to release a stop work order, an employer must provide evidence that it has come into compliance and it has paid the monetary penalty.

Where to Find Workers Compensation Insurance Coverage?

Contact an insurance agent. You can also contact the following insurance agent associations:

- **o** Florida Association of Insurance Agents at 850-893-4155
- **o** Professional Insurance Agents of Florida at 800-277-1171
- **o** Latin American Association of Insurance Agency at 305-477-1442

If you cannot obtain coverage through the standard workers' compensation market, you may contact the Florida Workers' Compensation Joint Underwriting Association (FWCJUA) at 941-378-7400 or visit their website at www.fwcjua.com. The workers' compensation rates in the FWCJUA will be higher than the rates in the standard market.

You may also consider entering into an employee leasing arrangement with a professional employer organization that has secured workers' compensation coverage on behalf of its clients.

How to Obtain a Construction Industry Exemption Application?

For additional information about workers' compensation coverage and the location of district offices nearest to you to obtain an exemption application, please call 1-800-742-2214.

You can download an exemption application and the instructions for completing it at the Division of Workers' Compensation website, which is www.fldfs.com/WC/forms.html. Click on forms "DWC 250" and "DWC 250 Instructions".

Construction Industry Exemption Eligibility Information

You must be an officer of a corporation or a member of a limited liability company (LLC). However, an officer of a corporation who elects to be exempt may not recover workers' compensation benefits.

You must show proof that you own at least 10% of the corporation or company.

**Your corporation or LLC must be registered with the Florida Department of State, Division of Corporations.

You must be listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.

You must list all certified or registered licenses issued to you pursuant to Chapter 489, Florida Statutes.

You must provide a copy of a current occupational license required by the city or county in which the business is located or performing regular work.

No more than three officers of a corporation (including LLC) or of any group of affiliated corporations (including LLCs) may elect to be exempt.

A $50.00 application fee is required if you are applying for a construction industry exemption.

****Out-of-state contractors that are corporations or limited liability companies can qualify as foreign corporations or foreign limited liability companies by filing specific forms and documentation with the Florida Division of Corporations. For more Information regarding the foreign qualification requirements, call (850) 245-6051. The forms can be accessed at www.sunbiz.org.**

DIVISION OF

DWC

WORKERS' COMPENSATION

Tom Gallagher, Chier Financial Officer

MANAGING WORKERS' COMPENSATION COSTS IN ILLINOIS

Workers' compensation claim management directly impacts the treatment of your injured workers and may impact your company's insurance costs as well. Illinois provides employers and their insurance companies with an important tool to help manage an injured worker's recovery and related costs.

"Right to direct" rules allow an employer to direct an injured employee to a preferred provider organization for medical care. This helps ensure that injured workers can access network care for treatment whenever possible. Network doctors are experienced in treating workplace injuries and working with our claims handlers. They have also agreed to negotiated rates. This means that The Hartford can better coordinate appropriate, cost effective care for workplace injuries.

Set up a Preferred Provider Program

Ensuring the right to direct treatment

By following the steps below, an employer can designate use of the Illinois Preferred Provider Program (PPP) and require that injured workers seek treatment through PPP network providers. While employees can opt out of the program, participation in the PPP can be a great benefit to the outcome of the claim in terms of the employee's recovery, return to work and related costs.

1. Employer delivers the Advisory Preferred Provider Program Notice to all employees. This step is optional but recommended by The Hartford to help ensure program acceptance.

2. Employer provides Mandatory Preferred Provider Program Notice and Acknowledgement to injured worker immediately after an injury occurs.

3. We recommend that the employer create a provider list from the Online Provider Search Tool at **http://www.talispoint.com/htfd/external/** or by calling The Hartford's Network Referral Unit at **1-800-327-3636** and selecting **4** at the prompt.

The forms noted above and additional information on The Hartford's Illinois Preferred Provider Program can be found at **www.thehartford.com/il-workers-compensation**.

Focus on return to work

Another advantage of using network doctors is their experience with return to work. Return-to-work programs are designed to help get injured workers back on the job, even if they haven't fully recovered from an injury. This approach often involves finding transitional duties that suit an injured worker's limited physical capabilities. An effective return-to-work program can improve employee satisfaction and retention and potentially impact your cost of doing business. Employers play a vital role in facilitating return to work. If you don't already have a return-to-work program, consider starting one at your company.

Form WC 66 04 16 Printed in U.S.A.

NEW YORK WORKERS' COMPENSATION

OCTOBER 1, 2021 RATE REVISION
EXPLANATORY MEMORANDUM

Notice of Final Rate Changes -

The following pages show the percentage (%) change in loss costs for each class. These percentage changes also reflect the percentage changes to the base rates charged for each class. The loss costs shown represent one component of the final rate charged. Your renewal premium will be based on the loss cost change along with other factors, such as a change in experience modification or payroll. The final rate charged for each class will be shown in the "Schedule of Operations" in your policy, which also calculates the premium as a result of the final rate change(s).

An overall loss cost decrease of 6.4% has been approved by the New York State Department of Financial Services to become effective on October 1, 2021.

The following is a description of the various components of the approved change:

Loss Experience – The latest two policy years of experience produced a decrease of 1.7% in the overall loss cost level.

Legislative Changes – This revision includes an estimate of the cost impact of the latest increases in the maximum weekly benefits that were set forth in the 2007 workers' compensation reform legislation. This component contributed an increase of 2.0% to the overall change.

Loss Adjustment Expenses – A review of the latest data available resulted in an increase of 0.6% in the Loss Adjustment Expense provision.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a continuing decrease in claim frequency, an upward trend in indemnity claim costs and a mild upward trend in medical claim costs. Combined with a projected wage trend, the final selected net trend factor is -6.3%.

Catastrophe Provision – This revision changes the loss cost for terrorism to $0.03 per $100 of total policy payroll (2.3% of premium for non-payroll classifications), representing a decrease of 33.3% from the previous provision. This revision also changes the loss cost for natural disasters and catastrophic industrial accidents to $0.005 per $100 of total policy payroll (0.4% of premium for non-payroll classifications), representing a decrease of 37.5% from the previous provision. These changes contribute a decrease of 1.1% to the overall change.

Classification Loss Costs – Although the average manual loss cost level is decreasing by 5.4%, individual classification loss cost changes are based on the most recently available loss experience for each classification. Both increases and decreases from the current loss costs have been actuarially calculated for each class. This process ensures that each classification loss cost reflects the appropriate level relative to the experience of the other classifications.

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
0005	1.72	1.91	-9.9%	2089	5.85	6.57	-11.0%
0006	2.32	2.75	-15.6%	2095	5.54	6.25	-11.4%
0007	1.56	1.80	-13.3%	2101	6.77	6.74	0.4%
0031	1.88	2.08	-9.6%	2105	4.69	5.63	-16.7%
0034	3.59	3.82	-6.0%	2111	2.04	2.25	-9.3%
0035	2.47	2.72	-9.2%	2112	6.68	7.84	-14.8%
0042	4.56	4.91	-7.1%	2114	7.17	6.84	4.8%
0050	2.63	3.42	-23.1%	2121	4.79	4.47	7.2%
0106	5.76	6.32	-8.9%	2143	3.10	3.39	-8.6%
0251	13.18	15.14	-12.9%	2150	8.07	9.21	-12.4%
0771	8.11	7.67	5.7%	2157	11.37	12.22	-7.0%
0908	163.50	145.89	12.1%	2172	3.81	3.40	12.1%
0909	211.06	178.26	18.4%	2288	6.02	6.85	-12.1%
0912	993.22	838.87	18.4%	2302	2.70	2.62	3.1%
0913	510.09	430.82	18.4%	2362	1.92	2.11	-9.0%
0917	3.86	4.15	-7.0%	2380	5.71	6.74	-15.3%
1170	2.85	3.25	-12.3%	2387	3.81	4.08	-6.6%
1320	4.02	4.58	-12.2%	2388	2.80	3.15	-11.1%
1430	2.64	3.11	-15.1%	2402	2.07	2.31	-10.4%
1438	8.82	9.52	-7.4%	2413	3.41	3.76	-9.3%
1439	4.06	4.88	-16.8%	2416	2.76	2.43	13.6%
1452	7.50	7.46	0.5%	2417	2.50	2.84	-12.0%
1463	5.38	6.05	-11.1%	2501	0.93	0.94	-1.1%
1470	8.49	9.73	-12.7%	2503	0.97	1.08	-10.2%
1624	3.58	3.98	-10.1%	2534	3.40	4.10	-17.1%
1701	4.07	4.47	-8.9%	2553	2.08	2.19	-5.0%
1710	5.86	5.99	-2.2%	2570	4.27	5.22	-18.2%
1741	7.58	7.36	3.0%	2571	3.23	3.47	-6.9%
1747	14.90	18.19	-18.1%	2576	3.22	3.17	1.6%
1748	7.37	8.12	-9.2%	2578	2.69	2.92	-7.9%
1809	9.30	10.60	-12.3%	2590	2.42	2.61	-7.3%
1810	6.09	7.57	-19.6%	2591	4.95	5.45	-9.2%
1860	6.28	8.58	-26.8%	2593	5.00	5.85	-14.5%
1924	4.14	4.95	-16.4%	2594	5.90	5.90	0.0%
1925	6.51	7.47	-12.9%	2600	6.62	6.91	-4.2%
2001	3.74	4.39	-14.8%	2623	3.26	3.82	-14.7%
2002	4.23	4.09	3.4%	2640	12.36	12.57	-1.7%
2003	5.31	5.37	-1.1%	2660	2.27	2.40	-5.4%
2014	3.77	3.38	11.5%	2670	3.84	3.46	11.0%
2021	3.47	3.46	0.3%	2683	4.61	4.86	-5.1%
2039	7.51	7.04	6.7%	2688	1.39	1.46	-4.8%
2041	3.43	3.82	-10.2%	2689	0.80	0.93	-14.0%
2065	2.51	2.92	-14.0%	2702	9.50	10.31	-7.9%
2070	5.59	5.76	-3.0%	2710	4.47	5.22	-14.4%
2081	8.01	9.38	-14.6%	2714	5.97	7.03	-15.1%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
2731	4.05	4.49	-9.8%	3191	2.59	3.14	-17.5%
2737	5.65	5.79	-2.4%	3200	3.02	3.10	-2.6%
2759	8.79	10.30	-14.7%	3220	2.54	2.61	-2.7%
2790	1.22	1.43	-14.7%	3227	28.44	29.89	-4.9%
2802	5.23	6.39	-18.2%	3241	5.60	4.90	14.3%
2817	3.52	3.88	-9.3%	3257	2.76	3.11	-11.3%
2835	2.13	2.43	-12.3%	3270	1.90	2.24	-15.2%
2841	4.41	4.78	-7.7%	3307	2.51	3.01	-16.6%
2881	3.30	3.01	9.6%	3315	12.02	11.48	4.7%
2883	2.95	3.41	-13.5%	3336	2.48	2.55	-2.7%
2913	6.83	6.26	9.1%	3365	7.31	7.54	-3.1%
2916	3.19	3.41	-6.5%	3372	2.68	2.57	4.3%
2923	3.07	2.66	15.4%	3381	1.62	1.87	-13.4%
2942	1.99	2.40	-17.1%	3383	0.49	0.53	-7.5%
3004	4.17	4.42	-5.7%	3384	0.25	0.24	4.2%
3018	8.46	9.57	-11.6%	3385	0.86	0.99	-13.1%
3022	6.12	6.96	-12.1%	3400	11.17	11.41	-2.1%
3027	2.12	2.58	-17.8%	3507	3.53	3.88	-9.0%
3028	7.54	8.65	-12.8%	3515	3.17	3.53	-10.2%
3030	8.73	9.33	-6.4%	3548	1.86	1.93	-3.6%
3040	8.15	7.72	5.6%	3559	4.24	4.30	-1.4%
3041	4.43	4.59	-3.5%	3561	2.84	2.75	3.3%
3042	4.64	4.91	-5.5%	3574	1.03	0.96	7.3%
3060	8.26	9.86	-16.2%	3581	1.53	1.68	-8.9%
3064	4.00	4.96	-19.4%	3612	2.69	2.64	1.9%
3066	3.58	3.60	-0.6%	3620	4.35	4.68	-7.1%
3067	3.11	3.27	-4.9%	3629	1.71	1.91	-10.5%
3076	3.22	3.47	-7.2%	3632	3.02	3.32	-9.0%
3081	4.03	4.46	-9.6%	3634	1.80	1.92	-6.2%
3085	7.02	7.61	-7.8%	3635	1.81	2.08	-13.0%
3110	7.90	10.04	-21.3%	3638	2.41	2.97	-18.9%
3111	3.66	4.39	-16.6%	3642	1.12	1.44	-22.2%
3113	2.00	2.04	-2.0%	3643	2.78	2.76	0.7%
3114	2.31	2.78	-16.9%	3647	4.87	4.40	10.7%
3118	2.12	2.26	-6.2%	3648	2.26	2.18	3.7%
3122	5.23	5.28	-0.9%	3681	1.10	1.26	-12.7%
3126	12.67	15.05	-15.8%	3685	1.41	1.54	-8.4%
3129	4.17	4.15	0.5%	3686	1.57	1.76	-10.8%
3132	1.78	2.03	-12.3%	3724	4.42	4.56	-3.1%
3145	2.22	2.26	-1.8%	3726	4.86	6.76	-28.1%
3146	1.59	1.64	-3.0%	3737	4.64	4.48	3.6%
3169	4.18	4.41	-5.2%	3807	4.26	4.84	-12.0%
3179	2.23	2.45	-9.0%	3808	3.95	4.16	-5.0%
3188	3.00	3.06	-2.0%	3821	6.67	7.48	-10.8%
3190	2.83	2.92	-3.1%	3823	3.97	4.45	-10.8%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
3824	4.05	4.51	-10.2%	4410	5.16	5.58	-7.5%
3826	1.47	1.61	-8.7%	4420	11.90	12.31	-3.3%
3827	3.92	4.73	-17.1%	4431	4.02	4.50	-10.7%
3830	1.70	2.37	-28.3%	4432	1.96	2.06	-4.9%
3832	2.26	2.51	-10.0%	4439	3.63	3.73	-2.7%
3865	2.63	2.82	-6.7%	4452	2.81	3.28	-14.3%
3881	3.56	(a)	0.0%	4459	3.71	4.06	-8.6%
4000	4.96	5.88	-15.6%	4470	4.32	4.68	-7.7%
4024	6.49	5.97	8.7%	4475	2.29	2.54	-9.8%
4034	8.38	8.88	-5.6%	4476	1.95	1.99	-2.0%
4038	2.52	2.89	-12.8%	4479	2.35	2.53	-7.1%
4053	3.26	3.99	-18.3%	4493	3.88	4.68	-17.1%
4061	3.09	3.72	-16.9%	4511	0.70	0.71	-1.4%
4062	7.08	6.85	3.4%	4557	1.18	1.31	-9.9%
4101	2.60	3.04	-14.5%	4558	3.90	4.35	-10.3%
4111	2.17	2.34	-7.3%	4568	2.23	2.46	-9.3%
4112	1.22	1.50	-18.7%	4583	6.95	6.57	5.8%
4114	2.61	2.67	-2.2%	4597	1.80	2.08	-13.5%
4130	5.18	6.37	-18.7%	4611	2.04	2.17	-6.0%
4131	4.64	4.37	6.2%	4628	2.06	1.96	5.1%
4133	3.21	3.26	-1.5%	4635	6.24	6.14	1.6%
4150	1.55	1.77	-12.4%	4653	3.39	2.99	13.4%
4207	0.89	1.03	-13.6%	4665	10.25	10.87	-5.7%
4239	2.68	2.80	-4.3%	4692	1.07	1.20	-10.8%
4240	3.79	4.48	-15.4%	4693	2.15	2.24	-4.0%
4243	3.31	3.67	-9.8%	4710	2.00	2.53	-20.9%
4244	2.85	3.00	-5.0%	4712	1.97	2.03	-3.0%
4250	2.72	2.81	-3.2%	4720	2.62	3.09	-15.2%
4251	2.08	2.33	-10.7%	4751	2.04	2.37	-13.9%
4263	3.55	4.05	-12.3%	4771	2.49	2.94	-15.3%
4273	3.47	3.43	1.2%	4825	0.79	0.86	-8.1%
4279	4.30	4.72	-8.9%	4828	2.50	2.39	4.6%
4282	0.32	0.37	-13.5%	4829	2.26	2.28	-0.9%
4298	1.93	2.20	-12.3%	4902	2.62	3.26	-19.6%
4299	2.26	2.33	-3.0%	4923	1.21	1.30	-6.9%
4301	6.56	7.29	-10.0%	5000	12.19	14.89	-18.1%
4304	11.52	11.16	3.2%	5022	18.14	19.23	-5.7%
4307	2.90	3.15	-7.9%	5037	29.64	29.54	0.3%
4310	2.44	2.71	-10.0%	5040	21.38	23.03	-7.2%
4312	2.98	3.16	-5.7%	5057	10.42	13.61	-23.4%
4351	2.09	2.11	-0.9%	5059	32.87	42.24	-22.2%
4352	0.56	0.66	-15.2%	5069	31.55	30.89	2.1%
4360	0.33	0.31	6.5%	5102	13.44	14.12	-4.8%
4361	0.52	0.59	-11.9%	5160	5.13	5.26	-2.5%
4362	0.39	0.48	-18.8%	5183	6.58	6.77	-2.8%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
5184	6.71	7.12	-5.8%	6204	7.91	7.20	9.9%
5188	5.71	6.11	-6.5%	6216	8.61	9.08	-5.2%
5190	4.83	4.94	-2.2%	6217	5.92	6.75	-12.3%
5191	1.28	1.34	-4.5%	6229	3.73	4.14	-9.9%
5192	5.07	4.88	3.9%	6233	4.39	4.85	-9.5%
5193	6.90	8.51	-18.9%	6235	6.56	6.59	-0.5%
5213	20.55	19.73	4.2%	6251	16.31	17.54	-7.0%
5221	11.32	11.28	0.4%	6252	2.44	2.81	-13.2%
5222	12.11	11.18	8.3%	6306	9.35	9.57	-2.3%
5223	6.24	6.99	-10.7%	6319	4.13	5.19	-20.4%
5348	8.34	8.64	-3.5%	6325	7.37	7.21	2.2%
5402	5.67	6.98	-18.8%	6400	5.62	5.48	2.6%
5403	13.72	13.75	-0.2%	6504	4.15	4.45	-6.7%
5428	7.07	7.15	-1.1%	6701	15.48	16.09	-3.8%
5429	7.01	7.12	-1.5%	6801	28.55	30.97	-7.8%
5443	9.60	8.32	15.4%	6811	4.29	4.55	-5.7%
5445	9.20	9.08	1.3%	6824	10.81	11.53	-6.2%
5462	7.37	8.16	-9.7%	6826	3.90	4.64	-15.9%
5473	28.17	29.64	-5.0%	6834	3.01	3.74	-19.5%
5474	9.74	9.63	1.1%	6836	3.17	3.29	-3.6%
5479	6.10	7.07	-13.7%	6843	10.28	12.15	-15.4%
5480	11.04	11.53	-4.2%	6854	2.59	2.77	-6.5%
5491	2.04	2.28	-10.5%	6872	12.77	15.79	-19.1%
5506	13.00	13.74	-5.4%	6874	46.02	52.90	-13.0%
5507	7.71	8.32	-7.3%	6875	92.33	97.43	-5.2%
5508	3.96	4.37	-9.4%	6882	8.02	6.83	17.4%
5536	6.02	6.56	-8.2%	6884	40.20	42.55	-5.5%
5538	7.35	6.95	5.8%	6885	57.96	61.14	-5.2%
5545	18.11	19.87	-8.9%	7016	10.37	9.59	8.1%
5547	8.97	10.34	-13.2%	7024	11.52	10.67	8.0%
5606	3.34	3.75	-10.9%	7038	3.02	3.32	-9.0%
5610	9.15	9.62	-4.9%	7046	2.53	2.91	-13.1%
5645	8.46	8.78	-3.6%	7047	20.16	18.97	6.3%
5648	12.89	15.49	-16.8%	7050	5.88	6.45	-8.8%
5651	7.80	7.64	2.1%	7090	3.36	3.69	-8.9%
5701	13.72	15.28	-10.2%	7098	2.81	3.24	-13.3%
5703	13.61	17.21	-20.9%	7099	4.92	5.66	-13.1%
5709	24.37	24.41	-0.2%	7133	4.53	4.66	-2.8%
5951	0.64	0.75	-14.7%	7197	7.35	7.92	-7.2%
5954	4.71	4.93	-4.5%	7201	2.74	3.40	-19.4%
6003	10.46	10.71	-2.3%	7207	3.65	4.14	-11.8%
6005	4.05	4.01	1.0%	7219	10.04	9.99	0.5%
6017	3.72	3.39	9.7%	7231	8.84	9.59	-7.8%
6018	8.61	9.67	-11.0%	7309	3.98	4.30	-7.4%
6045	4.41	4.64	-5.0%	7313	2.44	2.56	-4.7%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
7317	25.13	26.42	-4.9%	8008	0.97	0.97	0.0%
7327	26.88	28.29	-5.0%	8012	1.72	1.81	-5.0%
7333	5.58	6.09	-8.4%	8013	0.28	0.31	-9.7%
7335	6.20	6.76	-8.3%	8016	0.67	0.64	4.7%
7337	10.86	11.82	-8.1%	8017	1.31	1.45	-9.7%
7364	0.69	1.00	-31.0%	8018	3.36	3.58	-6.1%
7366	5.55	6.68	-16.9%	8021	5.62	6.02	-6.6%
7367	6.50	7.15	-9.1%	8025	0.91	1.00	-9.0%
7368	6.17	6.75	-8.6%	8031	1.96	2.10	-6.7%
7370	(c)	(c)	-14.6%	8032	0.99	1.02	-2.9%
7377	5.81	6.35	-8.5%	8033	3.41	3.71	-8.1%
7380	8.38	8.80	-4.8%	8034	4.53	4.72	-4.0%
7390	15.65	16.65	-6.0%	8039	1.93	2.03	-4.9%
7394	3.41	4.32	-21.1%	8043	1.04	1.18	-11.9%
7395	3.79	4.80	-21.0%	8044	3.43	3.64	-5.8%
7398	6.63	8.39	-21.0%	8046	2.69	2.98	-9.7%
7403	5.81	6.24	-6.9%	8047	1.28	1.41	-9.2%
7405	1.30	1.26	3.2%	8048	4.62	5.17	-10.6%
7421	0.59	0.64	-7.8%	8068	0.16	0.19	-15.8%
7422	1.61	1.97	-18.3%	8069	0.40	0.48	-16.7%
7431	0.54	0.55	-1.8%	8072	0.71	0.81	-12.3%
7445	0.27	0.30	-10.0%	8090	0.66	0.63	4.8%
7453	0.26	0.29	-10.3%	8102	4.53	5.75	-21.2%
7502	2.15	2.04	5.4%	8103	3.52	4.15	-15.2%
7515	2.10	1.86	12.9%	8105	2.00	2.22	-9.9%
7520	5.71	6.50	-12.2%	8106	6.27	6.75	-7.1%
7536	6.75	6.59	2.4%	8107	3.07	3.31	-7.3%
7538	4.15	4.82	-13.9%	8111	3.99	3.94	1.3%
7539	1.37	1.49	-8.1%	8116	1.37	1.64	-16.5%
7542	3.51	4.27	-17.8%	8199	3.63	3.53	2.8%
7580	3.80	4.47	-15.0%	8209	5.82	6.71	-13.3%
7590	7.99	7.67	4.2%	8215	4.28	5.00	-14.4%
7600	7.86	7.27	8.1%	8227	11.06	12.86	-14.0%
7601	4.23	4.03	5.0%	8232	5.29	5.58	-5.2%
7610	0.20	0.23	-13.0%	8235	5.23	5.94	-12.0%
7710	3.56	3.26	9.2%	8263	6.21	7.46	-16.8%
7711	(e)	(e)	2.8%	8264	5.99	6.85	-12.6%
7716	(e)	(e)	2.8%	8265	7.42	7.83	-5.2%
7720	3.43	2.78	23.4%	8280	13.68	14.53	-5.8%
7723	1.52	1.50	1.3%	8288	4.27	4.06	5.2%
7855	5.16	4.26	21.1%	8291	5.77	6.26	-7.8%
7998	1.62	1.53	5.9%	8292	4.69	5.65	-17.0%
7999	1.96	2.12	-7.5%	8293	8.92	8.95	-0.3%
8001	2.16	2.52	-14.3%	8350	9.60	10.34	-7.2%
8006	1.54	1.80	-14.4%	8353	5.44	4.97	9.5%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
8381	1.66	1.94	-14.4%	9019	2.89	3.39	-14.7%
8382	1.50	1.70	-11.8%	9025	14.53	15.67	-7.3%
8385	10.81	10.89	-0.7%	9026	4.06	4.37	-7.1%
8391	2.83	3.14	-9.9%	9027	12.31	10.40	18.4%
8392	2.49	2.46	1.2%	9028	3.03	3.20	-5.3%
8394	4.86	5.20	-6.5%	9029	4.60	5.26	-12.5%
8500	6.23	6.72	-7.3%	9030	4.51	4.95	-8.9%
8601	0.42	0.45	-6.7%	9040	4.41	5.46	-19.2%
8709	25.53	26.76	-4.6%	9044	3.19	3.99	-20.1%
8719	1.89	2.13	-11.3%	9048	2.38	2.43	-2.1%
8720	1.83	2.01	-9.0%	9051	2.63	3.12	-15.7%
8723	0.12	0.12	0.0%	9052	3.14	3.15	-0.3%
8726	2.02	2.45	-17.6%	9055	1.08	1.07	0.9%
8731	2.15	2.55	-15.7%	9058	4.84	4.87	-0.6%
8742	0.27	0.29	-6.9%	9059	8.56	8.73	-1.9%
8745	5.60	6.30	-11.1%	9060	1.35	1.45	-6.9%
8747	0.18	0.16	12.5%	9061	1.82	1.90	-4.2%
8748	0.99	1.05	-5.7%	9063	0.94	0.92	2.2%
8751	3.53	3.70	-4.6%	9065	0.97	1.05	-7.6%
8755	0.74	0.75	-1.3%	9071	1.65	1.78	-7.3%
8800	1.84	1.92	-4.2%	9072	1.78	1.98	-10.1%
8802	0.99	1.13	-12.4%	9074	1.02	1.15	-11.3%
8803	0.04	0.05	-20.0%	9088	7.51	9.08	-17.3%
8809	0.17	0.19	-10.5%	9089	0.34	0.38	-10.5%
8810	0.12	0.12	0.0%	9093	1.18	1.47	-19.7%
8820	0.11	0.12	-8.3%	9101	2.78	2.97	-6.4%
8829	3.18	3.33	-4.5%	9102	2.92	3.31	-11.8%
8831	1.10	1.21	-9.1%	9149	0.98	1.17	-16.2%
8832	0.37	0.39	-5.1%	9157	4.26	4.31	-1.2%
8833	1.14	1.19	-4.2%	9158	1.89	2.06	-8.3%
8838	0.59	0.59	0.0%	9159	1.20	1.26	-4.8%
8840	0.45	0.48	-6.2%	9160	1.50	1.52	-1.3%
8854	3.94	4.53	-13.0%	9178	3.90	3.82	2.1%
8855	0.12	0.12	0.0%	9179	6.26	6.77	-7.5%
8857	2.51	2.71	-7.4%	9180	2.71	2.58	5.0%
8864	3.09	3.30	-6.4%	9182	1.62	1.46	11.0%
8865	2.81	3.04	-7.6%	9186	4.49	5.35	-16.1%
8866	2.26	2.42	-6.6%	9220	6.77	7.42	-8.8%
8868	0.41	0.44	-6.8%	9402	5.00	5.71	-12.4%
8869	0.81	0.93	-12.9%	9403	10.40	10.76	-3.3%
8871	0.12	0.16	-25.0%	9410	7.19	7.39	-2.7%
8901	0.15	0.13	15.4%	9501	1.90	1.93	-1.6%
9014	4.21	4.59	-8.3%	9505	3.51	4.03	-12.9%
9015	1.80	1.83	-1.6%	9519	3.35	3.53	-5.1%
9016	3.48	3.75	-7.2%	9521	3.34	3.84	-13.0%

NEW YORK WORKERS' COMPENSATION
LOSS COST COMPARISON
OCTOBER 1, 2020 TO OCTOBER 1, 2021

Class Code	Oct. 2021	Oct. 2020	% Change	Class Code	Oct. 2021	Oct. 2020	% Change
9522	1.63	1.54	5.8%	9585	0.79	0.87	-9.2%
9526	11.12	12.37	-10.1%	9586	0.62	0.66	-6.1%
9527	30.13	28.19	6.9%	9600	2.04	2.06	-1.0%
9534	10.13	10.07	0.6%	9610	0.88	0.97	-9.3%
9539	8.80	9.92	-11.3%	9620	1.35	1.55	-12.9%
9545	13.88	15.76	-11.9%				
9549	3.16	3.49	-9.5%				
9552	11.34	12.92	-12.2%				
9553	4.69	5.41	-13.3%				

Legend:

(c) - Refer to Miscellaneous Values in the manual for loss costs.

(e) - Refer to Volunteer Firefighters schedule for loss costs. Loss cost change is the same for all population groups in this class.

IMPORTANT NOTICE
GEORGIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Georgia Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for Indemnity and/or Medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.7%	0.6%	0.4%	0.4%	0.3%	0.1%	0.1%
( )	200	1.3%	1.1%	0.9%	0.7%	0.5%	0.3%	0.3%
( )	300	1.8%	1.5%	1.3%	1.0%	0.7%	0.4%	0.4%
( )	400	2.3%	1.9%	1.6%	1.3%	0.9%	0.6%	0.6%
( )	500	2.7%	2.3%	2.0%	1.5%	1.1%	0.7%	0.7%
( )	1,000	4.5%	3.8%	3.4%	2.6%	1.9%	1.3%	1.2%
( )	1,500	5.8%	4.9%	4.4%	3.4%	2.6%	1.8%	1.6%
( )	2,000	6.8%	5.9%	5.2%	4.2%	3.1%	2.2%	2.0%
( )	2,500	7.8%	6.7%	5.9%	4.7%	3.6%	2.5%	2.4%

All indemnity and/or medical claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return this form to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

DEDUCTIBLE NOTICE OF ELECTION TO ACCEPT TEXAS WORKERS COMPENSATION BENEFITS

Texas law permits an employer to obtain Workers' Compensation insurance with a deductible. The deductible applies to benefits payable under Texas Workers' Compensation Law. The insurance applies only to benefits in excess of the deductible amount. The deductible applies separately to each accident or disease regardless of the number of people who sustain injury by such accident or disease or claim or medical-only claim. The deductible plans have been explained to me. Premium reductions are determined based on the deductible selected, and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

You are not required to choose a deductible. If you do choose one, your insurance company will pay the deductible amount for you, but you must reimburse the insurance company within 30 days after they send you notice that payment is due. If you fail to reimburse the company, they may cancel the policy, upon ten days written notice, and any resulting premium may be applied to the deductible amount owed.

If a deductible amount is desired, please indicate below.

( ) Yes, I want a deductible of: (select only one)

1 $ per accident

2. $ per claim

3. $ per medical-only claim

applied to benefits payable under the Texas Workers' Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement

(monthly, quarterly or other)

( ) No, I do not want a deductible applied to benefits payable under the Texas Workers' Compensation Law

( ) Yes, I do want a deductible policy, but am unable to obtain for the following reason:

CAMUNDA INC

Employer Name (print or type)

Date

08 WEC AP8931

Signature and Title

Policy Number

IMPORTANT NOTICE

COLORADO WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY DEDUCTIBLE ELECTION FORM

Colorado Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only. There are nine "Per Claim" deductible options available. They are:

( )	**NONE**
( )	**$ 500**
( )	**1,000**
( )	**1,500**
( )	**2,000**
( )	**2,500**
( )	**5,000**
( )	**10,000**
( )	**13,500**
( )	**15,500**
( )	**16,000**
( )	**16,500**
( )	**17,000**
( )	**17,500**
( )	**18,000**
( )	**18,500**

All medical and indemnity claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you have any questions, or desire one of these deductible amounts to apply to your coverage, please call your Agent for a quote. This offer is valid for thirty days after the effective date of the policy with which this notice is enclosed.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

Form WC 66 01 49 J Printed in U.S.A.
Process Date: 07/02/22 **Policy Expiration Date:** 08/11/23

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect a medical and indemnity deductible, and your policy is being renewed effective on or after January 1, 1997, you must make your election before the effective date of your policy, otherwise at the next renewal of your policy.

( ) $ 500	**( ) $ 2,500**
( ) $ 1,000	**( ) $ 5,000**
( ) $ 2,000	**( ) Do Not Elect**

( ) $ 2,500 with Aggregate	**( ) Do Not Elect**

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

OKLAHOMA WORKERS COMPENSATION MANDATORY OPTIONAL DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires carriers issuing a policy under the Administrative Workers' Compensation Act (AWCA) to offer deductibles, optional to the policyholder, for benefits payable under the AWCA.

This form is applicable to the optional deductibles required by 85A O.S. Section 95 and OAC 365:15-1-3.1.

All five deductible options set forth below must be fully disclosed to the prospective policyholder in writing. The policyholder is not required to select a deductible option, but if the policyholder chooses a deductible, the policyholder may choose only one combined (medical benefits and indemnity claims) deductible amount. Medical only claims are included in the eligibility for a combined medical and indemnity deductible. The maximum combined deductible, including medical benefits and indemnity claims, will be $5,000 per claim. Please carefully review the requirements for the deductible options outlined below.

DEDUCTIBLE OPTIONS

The combined optional deductible amounts are:

- **o** $1,000
- **o** $2,000
- **o** $3,000
- **o** $4,000
- **o** $5,000

EMPLOYER OBLIGATIONS IF A DEDUCTIBLE OPTION IS SELECTED

If the applicant employer chooses a deductible, the carrier must pay compensable claims to the person or medical providers entitled to the benefits conferred by the AWCA, and obtain reimbursement from the insured employer for the applicable deductible amount.

WARNING: The insured employer must reimburse the carrier within 60 days of a written demand. If the insured employer fails to reimburse the carrier within 60 days, the carrier may seek to recover the full amount of the claim from the insured employer. In addition, the nonpayment of deductible amounts must be treated in the same manner as nonpayment of premium for purposes of cancellation of the policy.

EXPERIENCE RATING MODIFICATION

Benefits paid by the insured employer under a deductible may not be treated as benefits paid so as to harm the experience rating of the employer, and will not be charged against the experience of the employer in accordance with OAC 365:15-1-3.1(d).

ACCEPTANCE/REJECTION

☐ Yes, I have read the optional deductible information summarized above and want the following deductible amount to apply to claims under the AWCA. I understand that this deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

MEDICAL AND INDEMNITY

- ☐ $1,000
- ☐ $2,000
- ☐ $3,000
- ☐ $4,000
- ☐ $5,000

ACCEPTANCE/REJECTION

- ☐ Yes, I understand that I am responsible for reimbursing my insurance company for the amounts of any deductible it pays.
- ☐ No, I do not want the optional deductible described in this form.

NAMED INSURED _____

ADDRESS _____

TITLE _____

SIGNATURE _____

DATE _____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

IMPORTANT NOTICE

NEW YORK WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New York Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
	$ 100	0.3%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
	$ 200	0.5%	0.4%	0.4%	0.3%	0.3%	0.1%	0.1%
	$ 300	0.8%	0.6%	0.5%	0.4%	0.3%	0.2%	0.2%
	$ 400	0.9%	0.7%	0.6%	0.5%	0.5%	0.3%	0.2%
	$ 500	1.1%	0.8%	0.8%	0.6%	0.5%	0.3%	0.3%
	$1,000	1.8%	1.4%	1.3%	1.0%	1.0%	0.6%	0.5%
	$1,500	2.3%	1.9%	1.7%	1.4%	1.3%	0.8%	0.6%
	$2,000	2.8%	2.3%	2.2%	1.7%	1.6%	1.0%	0.8%
	$2,500	3.3%	2.7%	2.6%	2.1%	1.9%	1.2%	1.0%
	$5,000	5.1%	4.4%	4.2%	3.5%	3.3%	2.1%	1.7%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return this form to:
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

IMPORTANT NOTICE

RHODE ISLAND WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Rhode Island Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

			A	B	C	D	E	F	G
( )	$	250	1.6%	1.1%	1.0%	0.8%	0.7%	0.5%	0.5%
( )	$	500	2.8%	2.1%	1.8%	1.5%	1.2%	0.9%	0.8%
( )	$	1,000	4.5%	3.4%	3.1%	2.5%	2.1%	1.6%	1.5%
( )	$	2,500	8.0%	6.3%	5.7%	4.8%	4.0%	3.3%	3.0%
( )	$	5,000	11.8%	9.7%	8.9%	7.6%	6.5%	5.4%	4.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

IMPORTANT NOTICE

MAINE WORKERS' COMPENSATION INSURANCE
INDEMNITY AND MEDICAL DEDUCTIBLE ELECTION FORM

Maine Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for indemnity benefits or medical benefits. Indemnity deductibles apply separately to each claim and medical deductibles apply to each accident.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
Hazard Group

			A	B	C	D	E	F	G
Indemnity	**( )**	**$1,000**	1.4%	1.1%	1.1%	1.0%	0.8%	0.7%	0.6%
	( )	**$5,000**	5.2%	4.3%	4.0%	3.7%	3.3%	2.8%	2.4%
Medical	**( )**	**$ 250**	2.6%	2.1%	1.9%	1.3%	1.0%	0.7%	0.7%
	( )	**$ 500**	4.3%	3.6%	3.3%	2.3%	1.8%	1.3%	1.3%

The $500 medical deductible can only be chosen if you qualify for experience rating.

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**
Issuing Office THE HARTFORD BUSINESS SERVICE CENTER 3600 WISEMAN BLVD SAN ANTONIO TX 78251		

WORKERS' COMPENSATION SELECTION OF DESIGNATED MEDICAL PROVIDER DISCLOSURE STATEMENT

If you select two Designated Medical Providers meeting the following qualifications, a premium credit will be applied to your policy. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

A qualified Designated Medical Provider is a medical provider, who:

1) **Has a knowledge of work injuries;**
2) **Is knowledgeable of fee schedules;**
3) **Is decisive on medical-maximum-improvement determinations;**
4) **Communicates with you, the employer on such issues as case management and wellness programs;**
5) **Is knowledgeable of the employers operations.**

The names of the providers must be posted and well publicized by you, the employer.

** SIGN AND RETURN **

I am aware of the availability of a premium credit of 2.5%, if I select two qualified Designated Medical Providers. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

Insured Signature _____

Policy Number 08 WEC AP8931

Issuing Office THE HARTFORD BUSINESS SERVICE CENTER
Issuing Office Address 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

Utah and Virginia Drug Free Workplace Credit

This form attests to your agreement to implement and/or continue to monitor the drug free workplace program you have established throughout the policy period. By signing this form, you agree to continue the following activities or notify us of your intent to discontinue such practices.

- Provide notice to employees and job applicants including a written statement containing the policy on employee drug use, type of drug testing that may be required, actions that can be taken if the test result is positive, consequences of refusing to submit to a drug test, and a list of all drugs for which you will test.

- Educate employees and supervisors about the drug free program in place.

- Require discharge or discipline of any employee whose drug test result is confirmed positive as well as follow-up testing; post-accident testing after every on-the-job accident or injury resulting in loss of work time; pre-employment drug testing; random and reasonable suspicion testing of existing employees; discharge or discipline employees for refusal to submit to drug testing; and maintain compliance with the drug free program throughout the year.

You also agree The Hartford has the right to inspect your records and/or workplaces to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Signature by or on behalf of the Insured: _____

Title: _____ Date _____

Company: CAMUNDA INC

Policy Number: 08 WEC AP8931

Applicable State(s): _____

WORKERS' COMPENSATION COST CONTAINMENT CERTIFICATION DISCLOSURE STATEMENT

Cost Containment Certification is available from the Colorado Workers' Compensation Cost Containment Board. If you obtain certification, your policy will be subject to a premium credit which will be shown separately on your policy.

PLEASE CHECK ONE (1) OF THE FOLLOWING BOXES BASED UPON YOUR BUSINESS ENTITY QUALIFICATION:

☐ I am aware if my business **does qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business has implemented a certified workers' compensation risk management program, my policy is subject to a 5% premium credit if the loss experience has improved since the last renewal date of workers' compensation insurance. This 5% premium credit is in addition to any schedule rating for which i may qualify.

or,

☐ I am aware if my business **does not qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business entity has implemented a certified workers' compensation risk management program, my policy is subject to the following premium credit:

Premium Dividend	Dividend Criteria
10%	If my business has been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If my business had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If my business had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
4%	If my business had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
2%	If my business had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If my business had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

PLEASE SIGN AND RETURN

Insured Signature _____

Policy Number 08 WEC AP8931

Issuing Office THE HARTFORD BUSINESS SERVICE CENTER
Issuing Office 3600 WISEMAN BLVD
Address SAN ANTONIO TX 78251

IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized $2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject this deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM (Form 09-01A)

Name of Employer: _____

Date Program Implemented: _____

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____
B. Phone No.: ( ) _____
C. Address: _____

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

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and I attest to the accuracy of the information submitted.

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

Kansas

Department of Labor

Workers Compensation Information for Kansas Employers and Employees

Commissioner of Insurance of Kansas

Department Created By Act
Approved March 1, 1871

K-WC 25 (Rev. 5-15)

Copies of election forms, accident reports, the Posting Notice (K-WC 40-A) and all other mandated posters are available to download at www.dol.ks.gov/WorkComp/frmpub2.aspx.

For additional information on workers compensation benefits, employer guidelines and other general information, contact:

Kansas Department of Labor
Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603-3105
(785) 296-4000
(800) 332-0353
Email: wc@dol.ks.gov
Website: www.dol.ks.gov

Follow us:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

For more information on workers compensation insurance rates and insurance carrier conduct, contact:

Kansas Department of Insurance
420 S.W. 9th Street
Topeka, Kansas 66612-1678
(785) 296-3071
(800) 432-2484
Email: commissioner@ksinsurance.org
Website: www.ksinsurance.org

Table of Contents

What Is Workers Compensation?

Workers compensation is a required insurance plan provided by the employer to pay employee benefits for job-related injuries, disability, or death that arise out of and in the course of employment.

Per K.S.A. 44-508, an injury by accident shall be deemed to arise out of employment if:

- There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
- The accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment.

The words "arising out of and in the course of employment" as used in the Workers Compensation Act shall not be construed to include:

- Injury which occurred as a result of the natural aging process or by the normal activities of day-to-day living;
- accident or injury which arose out of a neutral risk with no particular employment or personal character;
- accident or injury which arose out of a risk personal to the worker; or
- accident or injury which arose either directly or indirectly from idiopathic causes.

Benefits are paid at the employer's expense. Coverage begins the first day on the job.

The present law covers all Kansas employers except for those in certain agricultural pursuits or those with a gross annual payroll of $20,000 or less. All payroll is taken into account, including that paid in Kansas or elsewhere. If the employer is a sole proprietor or a partnership, the wages paid to the owners and any of their family members are not used in the computation of the gross annual payroll. Per K.A.R. 51-11-6, the provision in K.S.A. 44-505 excluding the payroll of workers who are members of the employer's family shall not apply to corporate employers. A corporate employer's payroll for purposes of determining whether the employer is subject to the workers' compensation act shall be determined by the total amount of payroll paid to all corporate employees even when a corporate employee has elected out of the workers' compensation act pursuant to K.S.A. 44-543.

Employees who are disabled due to a job-related injury or disease are entitled to:

- medical expenses to treat the job-related injury or illness; and
- income benefits to replace part of the wages lost due to disability.

If death results from a job-related injury or disease, benefits may be paid to the surviving spouse, dependents or heirs.

Purpose of the Law

Kansas passed its first workers compensation law in 1911. By regulating litigation and benefits, the law is designed to protect the interests of both employers and employees. Employers benefit by substituting a known expense (premiums) for the risk of large, unbudgeted expenses in the event of serious employee disabilities. Employees benefit because negligence of the employer is not an issue in determining liability. Workers compensation coverage is a no-fault system. The provisions of the Workers Compensation Act shall be applied impartially to both employers and employees. While initially aimed at hazardous jobs, the law now covers most workers.

Elections

Elections in or out of the Workers Compensation Act are options available to employers or employees. Depending on the circumstances, options may be available for:

- non-covered employers - e.g., those with payrolls of $20,000 or less or in certain agricultural pursuits;
- corporate employees owning 10 percent or more of stock;
- individuals, proprietors, or partnerships;
- employers seeking coverage for volunteers and other non-covered workers; and
- volunteer directors, officers or trustees of a nonprofit organization.

Example: A two-person partnership has two employees - a family member and a non-family member - and an annual payroll of $15,000. The partnership may elect to purchase coverage under the Act and to extend such coverage to both employees. The partners are not covered because they are considered to be the employer.

Election forms can be found online at www.dol.ks.gov.

Employee Rights and Responsibilities

Kansas law protects an employee's right and ease in obtaining workers compensation. Specifically:

- An employee cannot be fired, demoted or otherwise discriminated against for filing a claim in good faith.
- Employees must be informed of their rights and responsibilities in case of injury. In the event of employee death, such information must be furnished to the employee's beneficiaries.
- Employees must not be charged for the payment of workers compensation claims. Employers cannot deduct from pay or benefits to pay insurance premiums or claims.
- Employees may be entitled to compensation benefits from an employer subject to the Act regardless of insurance coverage.
- Employees may obtain free assistance by contacting the Workers Compensation Ombudsman's office at (800) 332-0353 or (785) 296-4000.
- The law provides specific penalties for employee or employer fraud in workers compensation cases. For assistance or more information, or to report suspected fraud, contact the Workers Compensation Ombudsman or the Fraud and Abuse office at (800) 332-0353 or (785) 296-4000.

Employer Responsibilities

Workers Compensation Insurance

Most employers are required by law to provide for the payment of workers compensation claims, at no expense to the employee. Employers may satisfy this requirement in one of three ways:

- **Workers compensation insurance:** obtained from a licensed insurance carrier; the employer pays the premiums and the insurance company pays the claims. The insurance carriers are regulated by the Kansas Insurance Department.
- **Self-insurance:** an individual employer must demonstrate to the State the financial ability to pay any claims that might arise. This program is administered by the Division of Workers Compensation.
- **Group-funded pool:** a group of employers meeting certain statutory requirements may form a self-insurance program to jointly insure their ability to pay claims. This program is administered by the Kansas Department of Insurance.

Intentional failure to provide for workers compensation payment in one of the above ways is a **class A misdemeanor** and subjects the employer to a civil penalty in an amount twice the annual premium the employer would have paid for insurance or $25,000, whichever amount is greater.

Employment categories excluded from the law are:

- certain agricultural pursuits;
- realtors who qualify as independent contractors;
- employers with gross annual payrolls of $20,000 or less;
- firefighters belonging to a firefighters relief association which has waived coverage under the workers compensation law; and
- certain owner-operator vehicle drivers covered by their own occupational accident insurance policy.

OTHER REQUIREMENTS

- Employers must post written notice K-WC 40-A advising employees what to do in case of injury.
- Per K.S.A. 44-557,"it is…the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained."

  As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at http://www.dol.ks.gov/WorkComp/edinews.aspx.
- **Immediately upon learning of an employee's injury or death, employers must furnish written information to the employee or employee's dependents on available benefits, the claims process, an employer or insurance company contact for workers compensation claims, and other matters as required by law.** Forms K-WC 27-A and K-WC 270-A (Spanish) are available from the Division of Workers Compensation website at www.dol.ks.gov/WorkComp/frmpub2.aspx.
- An insurer or self-insured employer shall provide the following notice to an insured worker on or with the first check for temporary disability benefits: *Warning: Acceptance of employment with a different employer that requires the performance of activities you have stated you cannot perform because of the injury for which you are receiving temporary disability benefits could constitute fraud and could result in loss of future benefits and restitution of prior workers compensation awards and benefits paid.*

If you need assistance, call (800) 332-0353 or (785) 296-4000.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014 is outlined in K.A.R. 51-9-17.

Categories of Disability Benefits

Temporary Total Disability

Exists when the employee, on account of injury, is unable to engage in any type of substantial and gainful employment. Benefits are paid for the duration of the temporary total disability (TTD). There is a one-week waiting period (seven calendar days) before TTD benefits are paid. If the disability continues for three consecutive weeks, the employee is reimbursed for the waiting period. Employees may collect medical benefits during the first week. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum. Temporary total compensation may not exceed $130,000 per injury.

Employees may **not** collect temporary total disability and unemployment benefits for the same weeks.

Temporary Partial Disability

Exists when the worker returns to any employment at a wage less than the time of injury wage. Compensation is calculated on a weekly basis and is paid until the wage loss is no longer present or the benefit maximum is reached, whichever comes first.

Benefits are 66.67 percent of the difference between the employee's average gross weekly wage before the injury and the employee's wage after the injury. Benefits may not exceed the state's statutory maximum.

Permanent Partial Scheduled Disability

Exists when there is complete or partial loss of or loss of use of a body part, such as an arm, due to a job-related injury. Compensation for permanent partial scheduled disability is limited to a percentage of the following schedule. A healing period is available in cases of amputation. Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum cap of $130,000.

Benefit Information Schedule

Loss of or loss of use of:	Weeks Paid:	Loss of or loss of use of:	Weeks Paid:
Shoulder……..	225	Thumb……..	60
Arm…….	210	1st (index) finger……	37
Forearm……	200	2nd (middle) finger……	30
Hand……..	150	3rd (ring) finger……	20
Leg…….	200	4th (little) finger……	15
Lower leg……..	190	Great toe……..	30
Foot……...	125	Great toe, end joint…….....	15
Eye……	120	Each other toe……..…	10
Hearing, both ears……..	110	Each other toe, end joint only…..	5
Hearing, one ear……	30		

Permanent Partial General Disability

Exists when a worker is disabled in a manner which is partial in character and permanent in quality, and which is not covered by the schedule above. For example, disability involving the back or the loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity; or the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or foot of the other lower extremity; or the loss of or loss of use of both eyes which is partial in character and permanent in quality are whole body disabilities and are not covered by the above schedule. Compensation for such "non-scheduled" or "whole body" disability is based on the greater of the following: the percentage of functional impairment; or, the employee's reduced ability to perform work tasks and the average weekly wage the employee is capable of earning after the injury. Employees earning 90 percent of pre-injury wage are limited to functional impairment.

Calculating Permanent Partial General Disability Benefits

1. **Calculate weekly benefit rate by identifying the smaller of these two amounts:** Gross average weekly wage x 66.67 percent; or the statutory maximum.
2. **Calculate allowable weeks of compensation:** Begin with 415 weeks. Subtract from 415 the number of weeks of temporary total disability paid, excluding the first 15 weeks of such temporary total paid. Multiply the difference by the percentage of disability.
3. **Calculate total benefits:** Multiply weekly benefit rate by allowable weeks of compensation.

Example: Average weekly wage is $875 at date of accident *(7/10/2011)*. Employee has collected 25 weeks of temporary total disability and has a 25 percent disability rating.

Weekly benefit rate: (use lesser amount)

$875 x .6667 = $583.36
statutory maximum (as of 7/1/11) $555

Allowable weeks of compensation:

415 - [25-15] = 415 - 10 = 405 weeks
405 weeks x .25 = 101.25 weeks

Maximum benefit amount:

101.25 weeks x $555 = $56,193.75

Our website has a Workers Compensation Calculation Program. The date program allows you to calculate time between two dates or to calculate the addition of days to a known date. The scheduled injury and whole body injury programs will allow you to compute the compensation benefits due to the claimant. Step-by-step instructions are provided for each program.

Permanent Total Disability

Exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, both legs or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis, or incurable imbecility or insanity, resulting from injury independent of all other causes, shall constitute permanent total disability.

Benefits are 66.67 percent of an employee's average gross weekly wage, but not less than $25 nor more than the statutory maximum. Total compensation may not exceed $155,000 per injury.

An employee is not allowed to receive more than one award of permanent total disability in a lifetime.

How Rates are Determined

Workers compensation insurance in Kansas is mandated by state law for most but not all employers. The premiums paid by the employers should be sufficient to cover the claims incurred by their insurance companies. Rates are adjusted based on the most recent premiums, investment income and losses reported by the insurance companies. The National Council on Compensation Insurance (NCCI) submits these rates annually to the insurance commissioner for approval.

The NCCI is a ratemaking organization, licensed by the Insurance Department, whose membership is primarily comprised of insurance companies. They develop the annual rate change needed based on the losses and premium reported to them by their member insurance companies.

The Kansas Insurance Department regulates the rates charged in Kansas. Each year, the Insurance Department reviews premiums, claims costs and other relevant data submitted by the NCCI to determine whether a rate change is supported. Currently, about 70 cents of every $1 collected in premiums is projected to cover the cost of paying workers compensation claims. Approximately 27.5 percent of each dollar is used by insurance carriers to cover other costs of doing business - e.g., administrative expenses, salaries and overhead. The margin of profit is projected at roughly 2.5 percent plus the earnings on investments.

After reviewing the rate filing, the commissioner of insurance generally approves an "overall" statewide premium change. This "overall" change is stated as a percentage (for example, a five percent overall increase); however, individual classification base rates may increase or decrease more than the "overall" change. Individual classification base rates must continue to reflect the experience (premiums and losses) of employers in each classification.

Premium Components

Workers compensation insurance premiums are calculated based on several factors. The primary factors are:

Base rate: the starting point in calculating premiums. The base rate or loss cost filed is by NCCI and all carriers are required to use it. The base rates can change annually due to statewide loss experience of all employers in the same classification. The companies multiply the base rate by their approved Loss Cost Multiplier (LCM) in order to determine the rate per $100 of payroll.

Classification: a key factor in determining what rate an employer will pay. Classification denotes the employer's type of business; hazardous jobs are more likely to result in substantial and costly claims and, therefore, usually have a higher rate. There are about 600 classifications in use in Kansas.

Experience rating: affects premium based on the frequency and severity of compensation claims of employers with sufficient premium size to be "experience rated." Currently, employers with an annual premium of at least $4,500 within the past two years, or if more than two years, an average annual premium of $2,250 or more are experience rated. Fewer and less expensive claims mean a lower experience modification factor, which means a lower premium.

Payroll size: employers with larger payrolls generate more workers compensation annual premiums than those with a smaller payroll in the same classification. However, the expenses incurred in issuing and servicing the policy do not increase in direct proportion to the policy premium. Consequently, a premium discount may be applied to policies with a larger premium to recognize this factor.

Also, some employers are subject to fixed payroll amounts. Partners, sole proprietors and members of a limited liability company who elect to cover themselves under a workers compensation insurance policy pay a premium based on a set payroll which is adjusted annually. The premium for an executive officer of a corporation is based on the actual payroll of the officer, subject to a set per-week minimum and maximum payroll which may be adjusted annually.

Factors Affecting Premiums

Three of the most important factors in reducing premiums are:

1. **Implementation of an accident prevention program:** these programs were mandated by 1993 legislation and are to be made available to employers by all insurance carriers and group-funded pools operating in Kansas. Because accident prevention programs have been shown to reduce the frequency and severity of injuries, they offer employers the potential to reduce premiums. Premium reduction is, of course, only one benefit of accident prevention that employers should consider.
2. **Assuring the proper classification(s) was used to calculate the premium**: the classification used on the policy should, as reasonably and accurately as possible, describe the employer's business and the employee's duties. The use of an inappropriate classification could result in the payment of an incorrect premium. If a classification does not seem to accurately describe a particular job, assistance in verifying that the proper classification was used or in obtaining a correction is available by calling the Insurance Department: (800) 432-2484 or (785) 296-3071, or visiting the website at www.ksinsurance.org.
3. **Use of deductible:** deductibles can be a cost-effective means of reducing premiums and are available in various amounts. Losses paid by the employer under the deductible shall not apply in calculating the employer's experience modification. The insurer shall pay the deductible amount and seek reimbursement from the insured employer for the applicable deductible amount.

General Information

How to Obtain Insurance

Workers compensation insurance coverage can be obtained by:

- contacting a licensed insurance agent;
- contacting the Kansas Insurance Department for information on group-funded pools; or
- contacting the Division of Workers Compensation for information on self-insurance.

Kansas Workers Compensation Insurance Plan (Assigned Risk Plan)

Any employer who is in good faith entitled to but unable to purchase coverage in the voluntary workers compensation insurance market can obtain coverage in the Assigned Risk Plan. This means an employer is assigned to an insurance carrier who is authorized to provide coverage. Assigned Risk Plan premiums are calculated using the same loss costs as if the coverage were purchased in the voluntary market; however, premiums may be higher due to differentials applied to assigned risk rates and individual employer loss experience.

For assistance and questions about the Assigned Risk Plan, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Insurance Rating Appeals Process

If an employer suspects the wrong classification or other incorrect factor is being used in calculating a premium, the rating may be appealed in writing to the insurance carrier from which the coverage was purchased. The employer may also appeal in writing to the Kansas Commissioner of Insurance by outlining the nature of the complaint or appeal.

For additional information, or for assistance in appealing or correcting a classification error or other rate problem, contact the Kansas Insurance Department at (800) 432-2484 or (785) 296-3071.

Division of Responsibilities

Responsibilities of the Employee:

- Notify your employer immediately. Per K.S.A. 44-520, for injuries on or after May 15, 2011, and before April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
  - 30 calendar days from the date of accident or the date of injury by repetitive trauma;
  - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
  - 20 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Per K.S.A. 44-520, for injuries on or after April 25, 2013, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates:
  - 20 calendar days from the date of accident or the date of injury by repetitive trauma;
  - 20 calendar days from the date such medical treatment is sought if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma; or
  - 10 calendar days after the employee's last day of actual work for the employer if the employee no longer works for the employer against whom benefits are being sought.
- Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manger.
- Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.
- The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the Workers Compensation Act or has suffered a work-related injury.

Responsibilities of the Employer:

- Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.
- Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

  As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at 785-296-4000 or 800-332-0353. You may access our website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

- **The employer is required** by K.S.A. 44-5, 102(a) to deliver information immediately to employee or legal beneficiary to assist in the claims process (material is available from the employer's carrier or the Division of Workers Compensation), including form K-WC 27-A or K-WC 270-A (Spanish).

Responsibilities of the Division of Workers Compensation:

- Makes official record of accident reports filed with the division.

Survivors' Benefits

The workers compensation law provides for survivors' benefits in the event of an employee's job-related death. Survivors do not need not be U.S. citizens or reside in the United States to receive compensation.

The weekly benefits are based on 66.67 percent of the employee's average weekly wage at the time of the accident or injury, but cannot exceed the statutory **maximum**. The **minimum** death benefit is 50 percent of the state's average weekly wage in effect on the date of accident. Total compensation benefits may not exceed $300,000, unless benefits are being paid to a dependent child under the age of 18. Funeral expenses up to $5,000 and all medical and hospital expenses related to the fatal injury are also covered.

An initial payment of $40,000 must be made to the surviving legal spouse or wholly dependent child(ren) or divided among them, 50 percent to the surviving legal spouse and 50 percent to the dependent children. This $40,000 payment is not subject to the eight percent discount normally allowed for lump sum payments. The initial payment shall be paid immediately.

Spouse and Children

If an employee is survived by a spouse but no dependent children, the spouse receives the entire weekly benefit. If an employee is survived by a spouse and children, the weekly benefit is paid half to the spouse and half to the children. If an employee is survived only by children, the weekly benefit is divided equally among the children.

Dependent children receive benefits until age 18, or until age 23 if they are full-time students or mentally or physically disabled, even if the benefits exceed the statutory limit at the time of the accident. Where required, the employer shall pay the costs of a court appointed conservator not to exceed $1,000.

Other Dependents

If survivors' benefits are paid to the spouse and/or children, they may not be paid to any other beneficiaries. In the case of unmarried employees leaving no dependent children, any other dependents who were wholly or partially dependent upon the employee may receive compensation.

Dependents other than spouse or children may collect weekly benefits subject to the maximum of $18,500, until they die, remarry or receive more than 50 percent of their support from another source.

Legal Heirs

If the employee leaves no spouse, dependent children or other dependents either wholly or partially dependent upon the employee, a lump sum payment of $25,000 shall be made to the legal heirs of the employee.

Conditions Affecting Benefits

Drugs and Alcohol

An employer is not liable for workers compensation benefits if an employee is impaired due to the use of alcohol* or drugs** and the impairment contributed to the injury or death. This includes the use of prescription or non-prescription medications; benefits may be allowed, however, if:

- the drugs or medications were taken in therapeutic doses; and
- the employee had not been impaired on the job from such medications within the past 24 months.

If it is shown that the employee was impaired at the time of the injury, there shall be a rebuttable presumption that the accident, injury, disability or death was contributed to by such impairment.

An employee's refusal to submit to a chemical test at the request of the employer shall result in the forfeiture of benefits under the Workers Compensation Act if the employer had sufficient cause to suspect the use of alcohol or drugs by the claimant, or if the employer's policy clearly authorizes post-injury testing.

The results of a chemical test shall be admissible evidence to prove impairment if the employer establishes that the testing was done under any of the following circumstances:

1. as a result of an employer-mandated drug testing policy, in place in writing prior to the date of accident or injury, requiring any worker to submit to testing for drugs or alcohol;
2. during an autopsy or in the normal course of medical treatment for reasons related to the health and welfare of the injured worker and not at the direction of the employer;
3. the worker, prior to the date and time of the accident or injury, gave written consent to the employer that the worker would voluntarily submit to a chemical test for drugs or alcohol following any accident or injury;
4. the worker voluntarily agrees to submit to a chemical test for drugs or alcohol following any accident or injury; or
5. as a result of federal or state law, or a federal or state rule or regulation having the force and effect of law, requiring a post-injury testing program and such required program was properly implemented at the time of testing.

*An employee is considered to be impaired from alcohol if the blood alcohol concentration at the time of injury is.04 or more.

**Confirmatory test cutoff levels (ng/ml)

Marijuana metabolite……	15		
Cocaine metabolite……..	150	Opiates:	
Amphetamines:		Morphine……	2000
Amphetamine……..	500	Codeine……..	2000
Methamphetamine……	500	6-Acetylmorphine……	10ng/ml
		Phencyclidine……	25

Safety Violations: K.S.A. 44-501(a)(1)

Compensation for an injury shall be disallowed if such injury to the employee results from:

1. the employee's deliberate intention to cause such injury;
2. the employee's willful failure to use a guard or protection against accident or injury which is required pursuant to any statutes and provided for the employee;
3. the employee's willful failure to use a reasonable and proper guard and protection voluntarily furnished the employee by the employer;
4. the employee's reckless violation of their employer's workplace safety rules or regulations; or
5. the employee's voluntary participation in fighting or horseplay with a co-worker for any reason, work related or otherwise.

The preceding shall not apply when it was reasonable under the totality of the circumstances to not use such equipment, or if the employer approved the work engaged in at the time of an accident or injury to be performed without such equipment.

Coronary Disease and Stroke

The law does not provide compensation for coronary or coronary artery disease or cerebrovascular injury (e.g., stroke), unless it is shown that the exertion of the work that caused the injury was beyond that required by the employee's usual job duties. Another exception is vascular injury caused by extreme heat.

Prior Disability Ratings/Pre-Existing Condition

Compensation for any permanent disability may be reduced by the existence of a rating on any applicable pre-existing disability.

K.S.A 44-501(e): An award of compensation for permanent partial impairment, work disability or permanent total disability shall be reduced by the amount of functional impairment determined to be pre-existing. Any such reduction shall not apply to temporary total disability, nor shall it apply to compensation for medical treatment.

K.S.A. 44-501(e)(1): Where workers compensation benefits have previously been awarded through settlement or judicial administrative determination in Kansas, the percentage basis of the prior settlement or award shall conclusively establish the amount of functional impairment determined to be pre-existing. Where workers compensation benefits have not previously been awarded through settlement or judicial or administrative determination in Kansas, the amount of pre-existing functional impairment shall be established by competent evidence.

Guidelines for Obtaining Medical Treatment

Who Pays?

Employers are responsible for all medical treatment necessitated by a job-related injury or disease. This includes:

- services of a licensed health care provider;
- surgical, hospital and other medical treatment;
- medications, medical and surgical supplies;
- nursing services;
- crutches and other medical apparatus;
- ambulance services; and
- transportation between the employee's home and the place of medical treatment, subject to a minimum of five miles round trip.

If an employer has workers compensation insurance, the insurance carrier is required to pay for applicable medical expenses. Uninsured employers subject to workers compensation laws are still responsible for the medical bills of covered employees.

Employers are legally entitled to choose the treating physician. If an employee self-selects a physician who is not authorized or agreed upon by the employer, the employer is responsible for only the first $500 in medical bills from such self-selected physicians.

Employer-Ordered Examinations

After obtaining whatever emergency medical care is necessary, an employee shall submit to any reasonable physical examination ordered by the employer. The employer can also require the employee to submit to ongoing examinations - up to twice monthly, or more often if specifically ordered by the Division of Workers Compensation. Employees may forfeit the benefits that are available if they refuse to submit to such examinations. Employees are entitled to know the results of any physical examination ordered by the employer. At the employee's request, the doctor conducting the examination must furnish the employee, within a reasonable time after the examination, a report identical to that sent to the employer or the employer's carrier. Employees are entitled to have their own doctor present at, and participate in, any medical examination ordered by the employer. If this is not allowed, or if employees are not furnished a copy of the medical report, then the examination ordered by the employer will not be allowed as evidence related to the claim.

Fraud and Abuse

Both the Division of Workers Compensation and the Kansas Insurance Department have units dedicated to the investigation of fraudulent or abusive acts and practices that occur with regard to the Workers Compensation Act. Acts or conduct that are considered to be fraudulent or abusive can generally be described as situations in which claimants, employers or companies fail or refuse to follow directives of the Workers Compensation Act. The Workers Compensation Act applies to the following:

- persons claiming benefits under Workers Compensation Act;
- employers subject to the requirements of the Workers Compensation Act;
- insurance carriers and group-funded self-insurance plans providing coverage for work-related injuries;
- any person, corporation, business, or health care facility providing treatment for work-related injuries;
- attorneys and other representatives of employers, employees, insurers or other entities involved in the administration of the Workers Compensation Act.

If the director, or the assistant attorney general assigned to the Division of Workers Compensation, has probable cause to believe a fraudulent or abusive act or practice that violates the Workers Compensation Act has occurred, a copy of any order and all investigative reports and any evidence in the possession of the Division of Workers Compensation which relates to such act shall be forwarded to the prosecuting attorney of the county in which the act occurred.

Any person who believes a violation of the Workers Compensation Act has occurred may notify the Division of Workers Compensation immediately and should send the information relating to the alleged violation to the division. The director shall evaluate the facts surrounding the alleged violation to determine the extent, if any, to which violations of the Workers Compensation Act exist. For more information, call (785) 296-4000 or (800) 332-0353; or send e-mail to wcfraud@dol.ks.gov.

Any person who has a complaint against an insurance company, or other person/entity regulated by the Kansas Insurance Department, regarding the handling of a workers compensation claim, should contact the Anti-Fraud Division at the Kansas Insurance Department. Complaints may be made by calling (800) 432-2484 or (785) 296-3071, in writing by sending information to the Anti-Fraud Division at 420 SW 9th, Topeka, KS 66612 or online at www.ksinsurance.org.

Coverage and Compliance

The Compliance section monitors and assists employers to ensure that they fulfill two requirements under the Workers Compensation Act:

1. to secure Workers compensation benefits for employees and
2. to file written reports of alleged work accidents.

Failure to secure workers compensation benefits or report accidents can result in monetary penalties against the employer. Failure to secure workers compensation benefits can also result in closure of the business.

Per K.S.A. 44-557, "it is…the duty of every employer to make or cause to be made a report to the director* of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director**, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained."

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 standards. For details contact Techs and Stats, Division of Workers Compensation at (785) 296-4000 or (800) 332-0353, or visit our EDI website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

*As of January 1, 2014, by "make or cause to be made a report to the director" is meant that an employer must report to the employer's insurer for workers compensation any accident witnessed by the employer, claimed or alleged, with sufficient timeliness to allow the insurer to file the accident report with the division within 28 days, as required by K.A.R. 51-9-17.

**The requisite form for reporting by the insurer as of January 1, 2014 is outlined in KA.R. 51-9-17.

When the director has reason to believe an employer has engaged in the knowing and intentional failure to secure the payment of workers compensation to its employees, the director shall issue and serve upon such employer a statement of the charges and shall conduct a hearing in accordance with the Kansas Administrative Procedure Act. The employer may be liable to the state for a civil penalty in an amount equal to twice the annual premium or $25,000, whichever amount is greater.

The director shall order employers to come under the Workers Compensation Act by:

1. insuring and keeping insured the payment of such compensation with an insurance carrier authorized to transact the business of workers compensation insurance in the state of Kansas;
2. showing to the director that the employer carries such employer's own risk and is what is known as a self-insurer and by furnishing proof to the director of the employer's financial ability to pay such compensation for the employer's self; or
3. maintaining a membership in a qualified group-funded workers compensation pool. The cost of carrying such insurance or risk shall be paid by the employer and not the employee.

For more information, call (785) 296-4000 or (800) 332-0353; or send e-mail to wccompliance@dol.ks.gov or go to www.dol.ks.gov.

Verify Coverage

You can check whether a business has workers compensation coverage online. The website provides public access to portions of the information reported by private workers compensation insurance carriers for use by the Kansas Department of Labor (KDOL). The accuracy of data from any third party cannot be guaranteed by the agency and KDOL is not responsible for the coverage information available through this link.

For additional help with verifying workers compensation coverage in Kansas, call Workers Compensation Coverage and Compliance at (785) 296-4000.

Safety and Health Services

Workplace safety and accident prevention is a key element of the law. This requirement was designed to reduce claims/losses which would hold down premiums for employers. Because rates are based on losses, the prevention of employee accidents through enhanced safety measures is one of the best ways employers can help keep rates down.

By law, insurance carriers and group-funded plans must provide accident prevention programs upon request to their insureds. Notice of such accident prevention programs must appear on the front page of every policy issued after July 1993.

Programs Offered by the Kansas Department of Labor

Consultation: offers assistance to private sector employers in safety and health program evaluations. Consultants offer advice in the recognition, evaluation, and control of hazards in the workplace. Assistance with program initiation and development is available. Training, both formal and informal, is performed in all areas of safety and health. All services are at no cost to the client.

Public Sector Compliance: monitors the public sector - cities, counties, state agencies and school districts - by performing compliance audits under K.S.A. 44-636 and/or K.S.A. 44-575(f). Occupational hazards are identified and program elements are assessed. Hazards must be abated within 60 days. Investigations of employee complaints, near misses and fatalities are also conducted.

Accident Prevention: evaluates insurance companies and group-funded self-insurance plans to ensure that they are offering and providing safety and health services at no charge to their insureds as required by law. The quality and quantity of these services are evaluated by trained consultants by directly reviewing insurance company records and contacting those insured who have requested and been provided services. Accident prevention assistance is available by emailing Accident Prevention@dol.ks.gov. You can also find information online at www.dol.ks.gov/Safety/accident.aspx.

Safety and Health Conference: the annual Kansas Safety and Health Conference brings industrial, academic, vendor and government safety representatives together. The conference is self-supporting and seeks to address the relevant safety issues in a variety of workshops and presentations.

Workplace safety and health assistance is available by calling (785) 296-4386 or by emailing indsafetyhealth@dol.ks.gov. You can also find information online under Workplace Safety at www.dol.ks.gov.

Ombudsman Services

The Kansas Division of Workers Compensation established a Claimant Advisory Section in 1978. In 1993 the Legislature followed a national trend and, by statute, created the ombudsman program. The workers compensation reform legislation of 1993 mandated an expanded role for the Claims Advisory Section to enable a more proactive approach to assisting all parties in understanding their rights and responsibilities under the Workers Compensation Act.

The division employs full-time personnel who specialize in aiding injured workers, employers, and insurance professionals with claims information and problems arising from job-related injuries and illnesses. The ombudsman acts in an impartial manner and is available to provide the parties with information about the current issues within the workers compensation system. For example, the ombudsman has current information on legislative changes or changes due to decisions made by the Workers Compensation Board or the courts. The ombudsman section also can assist with specific issues on current workers compensation claims.

Assisting Injured Workers with:

- Providing general information
- Obtaining medical treatment
- Benefits not being paid or not being paid on a timely basis
- Unpaid medical benefits
- Calculations of benefits
- Timely notification of employer
- Procedures for filing for a hearing
- Obtaining survivors' benefits
- Informal dispute resolution
- Mediation assistance
- Interpretation for Spanish-speaking workers

Assisting Employers/Insurance Companies with:

- Providing general information
- Posting Workers Compensation Notice (K-WC 40-A)
- Providing required information to injured workers (K-WC 27-A or K-WC 270-A)
- Timely submission of accident reports
- Timely and appropriate payment of medical services
- Election information
- Assistance with death benefit requirements
- Informal dispute resolution
- Assistance with Spanish-speaking workers
- Employer staff training on workers compensation issues
- Site visits for hands-on assistance

Ombudsman assistance is available either in person or by calling (785) 296-4000 or (800) 332-0353. You also may send an email to wc@dol.ks.gov. Additionally, forms are available for download at www.dol.ks.gov.

Employer Services Unit

For technical assistance, and presentations and training for employers, call (785) 296-4000 or (800) 332-0353, or email wcemployerservices@dol.ks.gov.

Mediation

Mediation was legislatively created in 1996 (K.S.A. 44-5,117) and can be utilized at any point during the workers compensation process. The statute was amended in 1998 to allow mediation by video conferencing. Mediation is not mandatory or a prerequisite to a hearing and it may be utilized at any time during the worker compensation process. The issues that can be mediated are not restricted to medical or temporary total disability benefits.

What is Mediation?

Mediation is a means of resolving disputes in an informal and non-adversarial atmosphere. The parties to a dispute use a neutral third party to facilitate the discussion. The mediator has no decision making authority or interest in the outcome to the dispute. The mediator's job is to assist the parties in identifying the issues in dispute and establishing common goals. The key to mediation is allowing the parties to work through their dispute and create their own agreements (self-determination).

Who are the Mediators?

The mediators are employees of the Division of Workers Compensation who have received special training in the process of mediation. The mediators used by the Division of Workers Compensation meet or exceed the requirements established by K.S.A. 5-501 and amendments thereto, and any relevant rules of the Kansas Supreme Court as authorized pursuant to K.S.A. 5-510, and amendments thereto. Mediators receive training in conflict resolution techniques, neutrality, agreement writing, ethics, role playing, communication skills, evaluation of cases and the laws governing mediation.

Representation and Assistance

Any party may be represented by an attorney at this mediation conference or may request assistance from the Ombudsman/Claims Advisory section. The absence of an attorney during the process does not mean legal representation cannot be obtained later if the dispute is not settled in this informal setting.

For additional information or to schedule a mediation conference, please call (785) 296-4000 or (800) 332-0353. Write to Mediation Section, Kansas Department of Labor, Division of Workers Compensation, 401 SW Topeka Blvd, Topeka, KS 66603-3182. You may send e-mail to wcmediation@dol.ks.gov.

Medical Services

The primary function of the Medical Services section is the administration of the Schedule of Medical Fees. The fee schedule is updated and revised on an annual basis to promote health care cost containment, yet insure the availability of necessary treatment and care for injured employees.

The Medical Services section is available to act as a liaison between health care providers, employers, employees, insurance carriers, group-funded pools or self-insured businesses. Additionally, the section conducts informal hearings to assist in the resolution of disputed medical claims and related payments involving health care providers.

For assistance in resolving issues related to fee schedule interpretation, payment disputes, etc., contact the Medical Services section at (785) 296-4000 or fax (785) 296-0025.

Vocational Rehabilitation

Vocational rehabilitation may be provided at the option of the employer or the employer's insurance carrier. General experience has shown that the longer the length of time away from work recovering from an injury, the greater the likelihood that an employee will need vocational rehabilitation to resume suitable work at comparable pay.

If the employer or insurance carrier does not choose to provide for vocational rehabilitation, the employee can ask the rehabilitation administrator for a referral to a provider of such services, at the employee's expense. The employee can also request a referral to the Division of Rehabilitation Services in the Kansas Department for Children and Families.

For assistance with vocational rehabilitation, contact the rehabilitation administrator's office in the Division of Workers Compensation at (800) 332-0353 or (785) 296-4000 or send email to wcrehab@dol.ks.gov.

Kansas Department of Labor
Division of Workers Compensation

Kansas Department of Insurance

Kansas

Department of Labor

Información de Compensación De Trabajadores para Empleadores y Empleados del Estado de Kansas

Commissioner of Insurance of Kansas

Department Created By Act
Approved March 1, 1871

Copias de las formas de elección, reportes de accidente, exhibición de aviso (K-WC 40-A) y todos los demás carteles obligatorios están disponibles para descargarse en www.dol.ks.gov/WorkComp/frmpub2.aspx.

Para obtener información adicional sobre los beneficios de compensación de trabajadores, directrices para empleadores y otra información general, contacte:

Departamento de Laboral de Kansas
División de Compensación de Trabajadores
401 SW Topeka Blvd., Suite 2
Topeka, Kansas 66603
(785) 296-4000
(800) 332-0353
Correo electrónico: wc@dol.ks.gov
Sitio en internet: www.dol.ks.gov

Síganos:

www.facebook.com/KansasDOL

www.twitter.com/KansasDOL

Para más información en tarifas de seguro para compensación de trabajadores y conducta de compañias aseguradoras, contacte:

Departamento de Seguros de Kansas
420 S.W. 9th Street
Topeka, Kansas 66612-1678
(785) 296-3071
(800) 432-2484
Correo electrónico: commissioner@ksinsurance.org
Sitio en internet: www.ksinsurance.org

Íncide

¿Qué es Compensación de Trabajadores?

Compensación de trabajadores es un plan de seguro requerido del empleador para pagar beneficios al empleado por lesiones relacionadas con el trabajo, incapacidad o muerte que surgen de y en el curso del empleo.`

De acuerdo al articulo de ley K.S.A. 44-508, se considerará que una lesión por accidente surge del empleo si:

- Hay una conexión causal entre las condiciones bajo las cuales el trabajo es requerido a ser realizado y el accidente resultante; y
- El accidente es el factor predominante causando la lesión, condición médica y la resultante discapacidad o impedimento físico.

Las palabras "surgen de y en el curso del empleo" como se usan en la ley de compensación de trabajadores no se interpretarán para incluir:

- Lesión que se produjo como resultado del proceso de envejecimiento natural o por las actividades normales del vivir diario;
- Accidente o lesión que surgió de un riesgo neutral sin empleo particular o de carácter personal;
- Accidente o lesión que surgió de un riesgo personal para el trabajador; o
- Accidente o lesión que surgió directa o indirectamente por causes desconocidas.

Los beneficos son pagados a expensas del empleador. La cobertura empieza el primer día de trabajo.

La presente ley abarca todos los empleadores de Kansas excepto aquellos en ciertas actividades agrícolas o aquellos con una nómina annual bruta de 20,000 dólares o menos. Toda nómina es tomada en cuenta, incluyendo la que es pagada en Kansas o en otras partes. Si el empleador es un único propietario o una miembro de una asociación, los salarios pagados a los propietarios y a culaquiera de sus familares no se utilizan en el cálculo de la nómina anual bruta. De acuerdo con K.A.R 51-11-6, la disposición en K.S.A. 44-505 excluyendo la nómina de trabajadores que son miembros de la familia del empresario no se aplicará a las corporaciones. La nómina de una corporación para el propósito de determinar si el empleador es sujeto a la ley de compensación del trabajadores o no, deberá ser determinada por la suma total de los sueldos pagados a los empleados corporativos incluso cuando un empleado de la corporación ha elegido no ser cubierto por la ley de compensación de los trabajadores en conformidad con K.S.A. 44-543.

Los empleados discapacitados debido a una enfermedad o lesión relacionada con el trabajo tienen derecho a:

- gastos médicos para tratar la lesión relacionada con el trabajo o la enfermedad; y
- beneficios de ingresos para sustituir parte del salario perdido debido a la discapacidad.

Si muerte resulta de una enfermedad o lesión relacionada con el trabajo, podrán pagarse beneficios al cónyuge sobreviveniente, dependientes o herederos.

Propósito de la ley

Kansas pasó su primera ley de compensación trabajadores en el año de 1911. Mediante la regulación de los litigios y los beneficios, la ley está diseñada para proteger los intereses de los empleadores y empleados. Los empleadores se benefician mediante sustituir un gasto conocido (primas) por el riesgo a largo plazo de gastos no presupuestados, en caso de discapacidad grave del empleado. Los empleados se benefician debido a que la negligencia del empleador no es una cuestión en la determinación de responsabilidad. Cobertura de compensación de trabajadores es un sistema sin culpa. Las disposiciones de la Ley de Compensación de Trabajadores se aplicarán imparcialmente a los empleadores y empleados. Aunque incialmente la ley estaba destinada a trabajos peligrosos, ahora cubre a la mayoría de los trabajadores.

Elecciones

Elecciones dentro o fuera de la Ley de Compensación de Travajadores son opciones disponibles para los empleadores o empleados. Dependiendo de las circunstancias, las opciones pueden estar disponsibles para:

- empleadores no cubiertos: por ejemplo, aquellos con nóminas de 20,000 dólares o menos o en ciertas activdades agrícolas;
- empleados de una corporación dueños de 10 por ciento o más de las acciones;
- individuos, propietarios o asociaciones;
- empleadores buscando cobertura para voluntarios y otros trabajadores no cubiertos; y
- directores voluntarios, funcionarios o administradores de una organización sin fines de lucro.

Ejemplo: Una asociación de dos personas tiene dos empleados: un miembro de la familia y uno que no es miembro de la familia: y una nómina annual de 15,000 dólares. La asociación puede optar por adquirir la cobertura bajo la ley y extender dicha cobertura a ambos empleados. Los socios no están cubiertos porque son considerados como el empleador.

Forma de elección pueden encontrase en el Internet en www.dol.ks.gov.

Derechos y Responsabilidades de los Empleados

La Ley del estado de Kansas protege el derecho del empleado y facilita la obtención de compensación del trabajador. Específicamente:

- Un empleado no puede ser despedido, degradado o discriminado de cualquier otra manera por la presentación de un reclamo en buena fe.
- Los empleados deben ser informados de sus derechos y responsabilidades en caso de lesión. En el caso de muerte del empleado, dicha información deberá aportarse a los beneficiarios del empleado.
- No se debe imponer un pago a los empleados para reclamos de compensación de trabajadores. Los empleadores no puede deducir del sueldo o de los beneficios para pagar las primas de sequros o reclamos.
- Empleados pueden tener derecho a beneficios de compensación de un empleador sujeto a la Ley independientemente de la cobertura del seguro.
- Empleados pueden obtener asistencia gratuita mediante ponerse en contacto con la oficina Ombudsman de Compensación de Trabajadores a los teléfonos (800) 332-0353 o (785) 296-4000.
- La ley estipula sanciones específicas por fraude tanto a empleados como empleadores en casos de compensación de trabajadores. Para más información o asistencia, o para reportar sospecha de fraude, póngase en contacto con la Oficina Ombudsman de Compensación de Trabajadores o la Oficina de Fraude y Abuso a los teléfonos (785) 296-4000 o (800) 332-0353.

Responsabilidades del Empleador

Seguro de Compensación de Trabajadores

La mayoría de los empleadores están obligados por ley a proveer el pago de reclamos de compensación de trabajadores, sin ningún costo para el empleado. Los empleadores deberán cumplir con este requisito de tres maneras:

- Seguro de compensación de trabajadores: obtenida de una compañia de seguros con licencia; el empleador paga las primas y la compañía de seguros paga los reclamos. Las compañías de seguros son reguladas por el Departamento de Seguros del estado de Kansas.

- Auto-seguro: un empresario individual debe demostrar al Estado de Kansas la capacidad financiera para pagar culaquier reclamo que pudiera surgir. Este programa es administrado por la División de Compensación de Trabajadores.
- Grupo financiero de fondo común: un grupo de empresarios que cumplen cietos requisitos legales pueden formar un programa de auto-seguro para asegurar conjuntamente su capacidad para pagar los reclamos. Este programa es administrado por el Departamento de Seguros del estado de Kansas.
- Falta deliberada de proveer el pago de compensación de trabajadores en una de las formas anteriores es un delito menor, clase A y somete al empleador a una pena civil en una cantidad dos veces la prima anual que el empleador hubiera pagado por sequor o 25,000 dólares, cualquiera de las cantidades que sea mayor.

Categorías de empleo excluidos de la ley son:

- ciertas actividades agrícolas;
- agentes inmobilarios que califican como contratistas independientes;
- empleadores con nóminas anuales brutas de 20,000 dólares o menos;
- bomberos pertenecientes a una asociación de socorro de bomberos que ha renunciado la cobertura bajo la Ley de Compensación de los Trabajadores; y
- ciertos conductores de vehículos que son propietarios y que están cubiertos por su propia póliza de seguro de accidente laboral.

Otros Requisitos

- Los empleadores deben exponer el aviso escrito (K-WC 40-A), comunicando a los empleados qué hacer en caso de un accidente.
- De acuerdo con la ley K.S.A. 44-557, *es...la responsabilidad de cada empleador de hacer o causar que se haga un reporte a el director* de cualquier accidente, reclamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones*.
- Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en: http://www.dol.ks.gov/WorkComp/edinews.aspx.
- **Inmediatamente al enterarse de la lesión o la muerte de un empleado, el empleador deberá suministrar información por escrito al empleado o a los dependientes del empleado sobre los beneficios disponibles, el proceso de reclamo, el empleador o compañía de seguros de contacto para reclamos de compensación de trabajadores y otros asuntos como es requerido por la ley.** Las formas K-WC 27-A y K-WC 270-A (en español) está disponibles en internet, en el sito de la División de Compensación de Trabajadores en: www.dol.ks.gov/WorkComp/frmpub2.aspx.
- Un empleador con seguro o auto-asegurado deberá suministrar el siguiente avios a un trabajador asegurado o con el primer cheque de beneficios de incapacidad temporal: *Advertencia: aceptación de empleo con un empleador diferente que requiere la realización de actividades que usted ha declarado que no puede realizar debido a la lesión por la que está recibiendo beneficios de incapacidad temporal puede constituir fraude y podría resultar en pérdida de beneficios en el futuro y la restitución de previas indemnizaciones y beneficios pagados.*

Si necesita ayuda, llame a (800) 332-0353 o (785) 296-4000.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A.R. 51-9 17.

Categorías de Beneficios por Incapacidad

Incapacidad Total Temporal

Existe cuando el empleado, a causa de una lastimadura, no ha podido participar en cualquier tipo de empleo sustancial y remunerativo. Beneficios son pagados por la duración de la incapacidad temporal total (TTD por sus siglas en inglés). Existe un período de espera de una semana (siete días consecutivos) antes de que los beneficios temporales (TTD) sean pagados. Si la discapacidad continúa por tres semanas consecutivas, el empleado es reembolsado por el período de espera. Empleados pueden obtener beneficios médicos durante la primera semana. Los beneficios temporales son 66.67 por ciento del promedio del sueldo semanal bruto del empleado, pero no menos de 25 dólares ni más que el máximo legal vigente. La compensación total no debe exceder de 130,000 dólares por lesión.

Los empleados no podrán cobrar beneficios de incapacidad total temporal y beneficios de desempleo por las mismas semanas.

Incapacidad Parcial Temporal

Existe cuando el trabajador regresa a cualquier clase de empleo ganado un sueldo inferior a aquel que tenía al tiempo de lesionarse. La compensación es calculada sobre una base semanal y se paga hasta que no hay más pérdida del sueldo o hasta que el máximo beneficio es alcanzado, lo que ocurra primero.

Los beneficios son 66.67 por ciento de la diferencia entre el salario promedio bruto semanal del empleado antes de la lesión y el salario del empleado después de la lesión pero no pueden exceder el máximo legal vigenete en el estado.

Incapacidad Parcial Permanente

Existe cuando hay pérdida total o parcial del uso de una parte del cuerpo, como un brazo, debido a una lesión relacionada con el trabajo. Compensación para una incapacidad parcial permanente se limita a un porcentaje de la tabla siguienete. Un período de curación está disponible en los casos de amputación. Los beneficios son 66.67 por ciento de un salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal de 130,000 dólares.

Lista de información de beneficios

Pérdida o pérdida del uso de:	semanas pagadas:	Pérdida o pérdida del uso de:	semanas pagadas:
Hombro……..	225	Dedo Pulgar……..	60
Brazo…….	210	Dedo índice……..	37
Antebrazo…….	200	Dedo medio……..	30
Mano……..	150	Dedo anular……..	20
Pierna……..	200	Dedo meñique……..	15
Pierna inferior…….	190	Dedo gordo del pie……..	30
Pie……..	125	Dedo gordo del pie (articulación de la punta) …….....	15
Ojo…….	120	Cada dedo del pie…….	10
Oído (ambos)……..	110	Cada dedo del pie (articulación de la punta) …….....	5
Oído (uno solo)……	30		

Incapacidad General Parcial Permanente

Existe cuando un empleado se ha incapacitado de tal manera que es de carácter parcial y de calidad permanente y que no está cubierto por lo enlistado anterior. Por ejemplo, discapacidad envolviendo la espalda o la pérdida del uso de un hombro, brazo, antebrazo o mano, de una extremidad superior, combinada con la pérdida o pérdida uso de un hombro, brazo, antebrazo o mano, de la otra extremidad superior; o la pérdida o pérdida de uso de una pierna, pierna baja o pie, de una extremidad inferior, combinado con la pérdida de o pérdida del uso de una pierna, pierna baja o pie, de la otra extremidad inferior; o la pérdida de o pérdida del uso de ambos ojos que es parcial en carácter y permanente en calidad son discapacidades de todo el cuerpo y no están cubiertos por la lista anterior. Compensación por tales discapacidades "no programadas" o "cuerpo entero" se basa en el mayor de lo siguienete: el porcentaje de impedimento funcional; o la capacidad reducida del empleado para realizar tareas de trabajo y el sueldo semanal promedio que empleado es capaz de ganar después de la lesión. Empleados ganando 90 por ciento del sueldo que tenían antes de la lesión están limitados a impedimentio functional.

Calculando beneficios de incapacidad general parcial permanente

1. Cálculo el porcentaje de beneficio semanal mediante la identificación de la menor de estas dos cantidades: Sueldo promedio semanal bruto x 66.67 por ciento; o el máximo legal vigente.
2. Cálculo de las semanas de compensación permitidas: se empieza con 415 semanas. De las 415, se restan las semanas en que se pagó incapacidad total temporal, excluyendo las primeras 15 semanas de TTD. Se multiplica la diferencia por el porcentaje de incapacidad.
3. Cálculo del total de los beneficios: Se multiplican los beneficios semanales por el número de semanas de compensación permitidas.

Ejemplo: El sueldo promedio semanal es 875 dólares en la fecha del accidente (10/07/2011). El empleado ha cobrado 25 semanas de incapacidad total temporal (TTD) y tiene una un porcentaje de incapacidad del 25 por ciento.

Beneficio seminal: (utilice la cantidad menor)

$875 x .6667 = $583.36
Máximo legal (a partir del 07/01/11) $555

Semanas de compensación permitidas:

415 - [25-15] = 415 - 10 = 405 semanas
405 semanas x .25 = 101.25 semanas

Cantidad de beneficio máximo:
101.25 semanas x $555 = $56,193.75

Nuestro sitio en Internet tiene un programa de cálculo de beneficios de compensación de trabajadores. El programa de fechas le permite calcular el tiempo entre dos fechas o para calcular la suma de días a una fecha conocida. Los programas de la lista de lesiones y lesiones del cuerpo entero le permitirán calcular los beneficios de compensación a la que tiene derecho el reclamante. Se proporcionan instrucciones paso a paso para cada programa.

Incapacidad Total Permanente

Existe cuando el empleado, a causa de la lesión, ha quedado completa y permanentemente incapaz de participar en cualquier tipo de empleo remunderado y sustancial. Pérdida de ambos ojos, ambas manos, ambos brazos, ambos pies, ambas piernas o cualquier combinación de éstas, en ausencia de prueba de lo contrario, deberán constituir una incapacidad permanente total. Parálisis total considerable o imbecilidad incurable o locura, resultantes de lesions independientes de todas las otras causas, también constituirán incapacidad total permanente.

Los beneficiios son 66.67 por ciento del salario promedio bruto semanal del empleado, pero no menos de 25 dólares ni más que el máximo legal. La compensación total no debe exceder 155,000 dólares por lesión.

Un empleado no puede recibir más de una indemnización de incapacidad total permanente en la vida.

Cómo se Determinan las Tasas de Interés

El seguro de compensación de trabajadores en Kansas es obligatorio por la ley estatal para la mayoría, pero no para todos los empleadores.

Las primas pagadas por los empleadores deberían ser suficientes para cubrir los reclamos incurridos por sus compañias de seguros. Las tasas de interés se ajustan en función de las primas más recientes, los ingresos de inversión y pérdidas reportadas por las compañias de seguros. El Consejo Nacional de Seguros Compensatorios (NCCI por sus siglas en inglés) presenta estas tasas de interés anualmente al Comisionado de Seguros para su aprobación.

El Consejo Nacional de Seguros Compensatorios (NCCI) es una organización clasificadora, autorizada por el departamento de seguros, cuya composición, primordialmente consta de compañias de seguros. Ellos desarrollan el cambio necesario de la tasa de interés anual basándose en las pérdidas y primas reportadas a ellos por las compañias de seguros miembros de dicha organización.

El Departamento de Seguros de Kansas regula las tarifas que se cobran en el estado. Cada año, éste Departamento revisa las primas, los costos de los reclamos y otros datos pertinentes presentados por el NCCI para determinar si se recomienda un cambio en la tasa de interés o no. Actualmente, alrededor de 70 centavos de cada dólare recogidos en el cobro de las primas, se proyecta para cubrir el costo de pagar reclamos de compensación de trabajadores. Aproximadamente 27.5 por ciento de cada dólar es utilizado por las compañias de seguros para cubrir otros costos de hacer negocios: por ejemplo, gastos administrativos, salarios y gastos generales. El margen de beneficio se proyecta en aproximadamente un 2.5 por ciento Además de las ganacias de las inversiones.

Después de revisar la presentación de la tasa de interés, el Comisionado de seguros generalmente aprueba un cambio "global" en la prima estatal. Este cambio "global" se expresa como un porcentaje (por ejemplo, un cinco por ciento de aumento global); Sin embargo, los tipos básicos de clasificación individual pueden aumentar o disminuír más del cambio "global." Los tipos básicos de clasificación individual deben continuar reflejando la experiencia (las primas y pérdidas) de los empleadores en cada clasificación.

Componentes de la Prima

Las primas de seguro de compensación de trabajadores se calculan basándose en varios factores. Los principales son:

Tasa de interés básica: el punto de partida para el cálculo de las primas. La tasa de interés o costo de pérdida es presentado por NCCI y todas las aseguradoras requeridas de usarla. Esta podría cambiar anualmente basada en la experiencia de la pérdida de otros empleadores en todo el estado en la misma clasificación. Las compañias multiplican la tasa de interés por su Multiplicador de Costo de pérdida aprobado para determiner la tasa de interés por cada 100 dólares de nóminia.

Clasificación: un factor clave para determiner la tasa de interés que un empleador pagará. La clasificación denota la tipo de negocios; trabajos peligrosos tienen más probabilidades de provocar reclamos importantes y costosos y, por tanto, tienen una tasa de interés más alta. Hay unas 600 clasificaciones en uso en Kansas.

Clasificación basada en la experiencia: afecta la prima basada en la frecuencia y gravedad de los reclamos de compensación de los empleadores con tamaño de prima suficiente para ser "clasificados por experiencia." Actualmente, los empleadores con una prima anual de por lo menos 4,500 dólares en los últimos dos años, o si más de dos años, una prima promedio anual de 2,250 dólares o más son calificados de experiencia. Más pocos y menos costosos reclamos significan un factor modificación por experiencia más bajo, lo que significa una prima menos costosa.

Tamaño de la nómina: los empleadores con grandes nóminas generan primas anuales de compensación de trabajadores mayores que aquellos con una nómina más pequeña en la misma clasificación. Sin embargo, los gastos de distribución y abastecimiento de la póliza no incrementa en proporción directa a la prima de la póliza. En consecuencia, un descuento en la prima puede aplicarse a las pólizas con una prima más grande para reconocer este factor.

También, algunos empleadores están sujetos a cantidades de nómina fija. Socios, propietarios y miembros de una compañia de responsabilidad limitada que eligen cubrirse bajo una póliza de seguro de compensación de trabajadores pagan una prima basada en una nómina fija la cual se ajusta anualmente. La prima para un funcionario ejecutivo de una empresa se basa en la nómina actual del oficial, sujeta a una nómina mínima y un máxima establecida por semana, la cual que puede ser ajustada anualmente.

Factores que Afectan a las Primas

Tres de los factores más importantes en la reducción de las primas son:

1. **Implementación de un programa de prevención de accidentes:** estos programas fueron ordenados por la legislatura de 1993 y están disponibles a los empleadores por todas las compañias de seguros y grupo financiado por un fondo común operando en Kanas. Porque los progamas de prevención de accidentes han demostrado reducir la frecuencia y la gravedad de las lesiones, que ofrecen a los empleadores la posibilidad de reducir las primas. La reducción de la prima es, por supuesto, sólo uno de los beneficios de la prevención de accidentes que los empleadores deben tener en cuenta.
2. **Asegurándose que la(s) clasificación(es) adecuada(s) ha(n) sido usada(s) para calcular la prima:** la clasificación utilizada en la póliza debe describer, tan razonable y preciso como sea posible, el negocio del empleador y los deberes del empleado. El uso de una clasificación inadecuada puede resultar en pago de una prima incorrecta. Si la clasificación no parece describir con precision un trabajo en particular, ayuda para verificar que se utilizó la clasificación adecuada o para obtener una corrección, está disponible llamando al Departamento de Seguros al teléfono: (800) 432-2484 o (785) 296-3071 o visitando el sitio en internet **www.ksinsurance.org.**
3. **Uso de deducible:** los deducibles pueden ser una manera efectiva de reducir las primas y están disponibles en diversas cantidades. No se aplicarán las pérdidas pagadas por el empleador bajo el deducible para calcular la modificación de la experiencia del empleador. El asegurador deberá pagar el importe de deducible y solicitar el reembolso del empleador asegurando por la cantidad del deducible aplicable.

Información General

Cómo Obtener un Seguro

Cobertura de seguro de compensación de trabajadores puede obtenerse por:

- ponerse en contacto con un agente de seguros con licencia;
- ponerse en contacto con el departamento de seguros de Kansas para obtener información sobre grupos financiados por el grupo; o
- ponerse en contacto con la División de compensación de trabajadores para obtener información sobre auto-seguro.

Plan de Seguro de Compensación para Trabajadores de Kansas (Plan de Riesgo Asignado)

Cualquier empresario que tenga derecho pero que no pueda adquirir cobertura en el mercado de seguros de indemnización de trabajadores voluntario, puede obtener cobertura en el Plan de riesgo Asignado. Esto significa que un empleador es asignado a una compañia de seguros que está autorizada para proporcionar cobertura.

Las primas para el Plan de Riesgo Asignado se calculan utilizando los mismos costos de pérdida como si la cobertura hubiese sido comprada en el mercado vuluntario; sin embargo, las primas pueden ser mayors debido a recargos adicionales que se basan en la tamaño del empleador de prima y pérdida de experiencia.

Para asistencia y pregunatas relacionadas al Plan de Riesgo Asignado llame al Departamento de Seguros del estado de Kansas a los teléfonos (800) 432-2484 o (785) 296-3071.

Proceso de Apelación de Clasificación de Seguro

Si un empleador sospecha de una clasificación errónea u que otro factor incorrecto has sido utilizado para calcular una prima, la clasificación puede ser apelada por escrito a la compañia de seguros de la que se obtuvo la cobertura. El empleador también puede apelar por escrito al Comisionado de Seguros del estado de Kansas resumiendo la naturaleza de la queja o apelación.

Para información adicional o asistencia para apelar o corregir un error de clasificación o otro problema de clasificación, comuníquese con el Departamento de Seguros de Kanasas al (800) 432-2484 o (785) 296-3071.

División de Responsabilidades

Responsabilidades del Empleado:
Notificar al empleador inmediatamente. De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Mayo 15, 2011, y antes de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 30 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma reptitivo;
- 20 días consecutivos a partir de la fecha que recibío tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 20 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

De acuerdo al artículo de Ley K.S.A. 44-520, para lesiones en o después de Abril 25, 2013, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de las siguientes fechas:

- 20 días consecutivos a partir de la fecha del accidente o la fecha de lesión por trauma reptitivo;
- 20 días consecutivos a partir de la fecha que recibío tratamiento médico si el empleado está trabajando para el empleador en contra del que se buscan beneficios y tal empleado busca tratamiento médico de cualquier lesión por accidente o trauma repetitivo; o
- 10 días consecutivos después del último día de trabajo del empleado para el empleador si el empleado ya no trabaja para el empleador contra quien se buscan beneficios.

El aviso podrá darse verbalmente o por escrito. Donde el aviso se proporciona oralmente, si el empleador tiene designado a un individuo o departamento a quien debe darse el aviso y tal designación ha se comunicada por escrito al empleado, aviso a cualquier otra persona o departamento será insuficiente en esta sección. Si el empleador no ha designado a un individuo o departamento a quien debe darse aviso, el aviso debe proporcionarse a un administrador o supervisor.

Donde el aviso es provisto por escrito, aviso debe enviarse a un supervisor o gerente en la ubicación principal de trabajo del empleado.

El aviso, ya sea que se suministre oralmenete o por escrito, deberá incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser evidente a partir del contenido del aviso de que el empleado está cobrando beneficios bajo la Ley de Compensación de Trabajadores o ha sufrido una lesión relacionada con el trabajo.

Responsabilidades del Empleador:

- A menos que esté auto-asegurado, el empleador debe informar a su compañia de seguros o grupo financiero con fondos en común de la lesión del empleado.
- El empleador/compañía aseguradora debe presentar un informe de accidente con la división dentro de 28 días a partir de la fecha de conocimiento del empleador acerca de la lesión.
- El empleador es requerido por el artículo de ley**,** K.S.A. 44-5, 102(a) para entregar información al empleado o beneficiario legal inmediatamente para ayudar en el proceso de reclamos (material está disponible con la compañia aseguradora del empleador o en la División de Compensación de Trabajadores), incluyendo el formulario K-WC 27-A o K-WC 270-A (español).

Responsabilidades del División de compensación de trabajdores:

- Hace el registro oficial de informes de accidentes presentados ante la División.

Beneficios para los Sobrevivientes

La ley de compensación de los trabajadores provee beneficios para sobrevivientes en caso de fallecimiento relacionado con el trabajo. Los sobrevivientes no necesitan ser ciudadanos estadounidenses o residir en los Estados Unidos para recibir compensación.

Los beneficios semanales se basan en el 66.67 por ciento del salario semanal promedio del empleado en el momento del accidente o lesión, pero no pueden exceder el máximo legal. El beneficio de fallecimiento mínimo es de 50 por ciento del salario semanal promedio del Estado en vigor en la fecha del accidente. Los beneficios de compensación total no puede exceder la cantidad de 300,000 dólares, a menos que se les esté pagando beneficios a dependientes menores de 18 años. Los gastos de funeral

hasta 5,000 dólares, así como todos los gastos médicos y de hospital relacionados con la lesión fatal también son cubiertos.

Un pago inicial de 40,000 dólares debe ser hecho al cónyuge legal sobreviviente o niño(s) completamente dependientes o dividido entre ellos, un 50 por ciento para el cónyuge legal y 50 por ciento al (los) niño(s) dependiente(s). Este pago de 40,000 dólares no está sujeto al ocho por ciento de descuento que normalmente es permittido en los pagos globales. El pago inicial deberá ser pagado inmediatamente.

Cónyuge e Hijos

Si un empleado es sobrevivido por un cónyuge pero sin hijos dependientes, el cónyuge recibe todo el beneficio semanal. Si un empleado es sobrevivido por un cónyuge e hijos dependientes, el beneficio semanal es pagado la mitad el cónyuge, y la otra mitad a los hijos dependientes. Si un empleado es sobrevivido solo por los hijos dependientes, el beneficio semanal es dividido en partes iguales entre los hijos.

Los hijos dependientes reciben beneficios hasta la edad de 18 años, o hasta la edad de 23 años si son estudiantes de tiempo completo o están mental o fisicamente discapacitados, incluso si los beneficios superan el límite legal en el momento de la accidente. Donde es requerido, el empleador deberá pagar los costos de un conservador nombrado por un tribunal sin exceder la cantidad de 1,000 dólares.

Otros Dependientes

Si los beneficios de sobrevivientes son pagados al cónyuge y/o a los hijos dependientes, no pueden ser pagados a cualquier otro beneficario. En el caso de un empleado soltero sin hijos dependientes, otro beneficiario, dependiente total o parcialmente del empleado puede recibir la compensación.

Los dependientes que no sean el cónyuge o hijos dependientes pueden percibir los beneficios semanales hasta un máximo de 18,500 dólares, o hasta que fallezcan, se casen o reciban más del 50 de su sustento de otra fuente.

Herederos Legales

Si el empleado no deja cónyuge, hijos dependientes o otros beneficiarios ya sea total o parcialmente dependientes del empleado, un pago único de 25,000 dólares deberá ser hecho a los herederos legales del empleado.

Condiciones que Afectan los Beneficios

Alcohol y Estupefacientes

Un empleador no es responsable de beneficios de compensación de trabajadores si un empleado está incapacitado debido al uso de alcohol* o estupefacientes** y la incapacidad contribuyó a la lesión o fallecimiento. Esto incluye el uso de medicamentos con o sin receta médica; sin embargo, los beneficios pueden ser permitidos, si:

- los fármacos o medicamentos fueron tomados en dosis terapéuticas; y
- el empleado no estado incapacitado en el trabajo por dichos medicamentos en los últimos 24 meses.

Si se demuestra que el empleado estaba incapacitado en el momento de la lesión, deberá haber una presunción refutable de que el accidente, lesions, discapacidad o fallecimiento fueron contribuidos por dicha deficiencia.

Si el empleado rehúsa someterse a un examen químico a petición del empleador resultará en pérdida del derecho de beneficios bajo la ley de compensación de trabajadores, si el empleador tuviera suficientes motivos para sospechar el uso de alcohol o estupefacientes por el reclamente, o si la póliza del empleador autoriza claramente las pruebas después de una lesión.

Los resultados del examen químico deberán ser evidencia admisible para demostrar la incapacidad si el empleador establece que el examen se realizó bajo cualquiera de las siguinetes circunstancias:

1. como resultado de una póliza del empleador por escrito, donde es obligatorio el examen para uso de estupefacientes, establecida antes del la fecha del accidente o lesión, requiriendo a cualquier trabajador que se someta a exámenes de estupefacientes o alcohol;

2. durante una autopsia o en el curso normal de tratamiento médico por motivos relacionados con la salud y el bienestar del trabajador lesionado y no a dirección del empleador;
3. el trabajador, antes de la fecha y hora del accidente o lesión, dio el consentimiento por escrito al empleador de que el trabajador se sometería voluntariamente a un examen químico de estupefacientes o alcohol seguido de cualquier accidente o lesión;
4. el trabajador acepta vountariamente someterse a un examen químico de estupefacientes o alcohol después de cualquier accidente o lesión; o
5. como resultado de la ley federal o estatal, o norma federal o estatal o una regulación teniendo la fuerza y efecto de la ley, requiriendo un programa de pruebas después de la lesión y dicho programa requerido fue correctamente implementado en el momento de la prueba.

*Un empleado es considerado de estar incapacitado por uso de alcohol si la concentración de alcohol en la sangre es de 0.04 o más en el momento de la lesión.

**Niveles límite de prueba confirmatoria (ng/ml)

Marihuana metabólica…….	15	Opiáceos:	
Cocaína metabólica ……..	150	Morfina……..	2000
Anfetaminas:		Codeína……	2000
Anfetamina……..	500	6-Acetylmorphine……	10ng/ml
Metanfetamina……..	500	Phencyclidine…….	25

Violaciones de Seguridad: K.S.A. 44-501(a)(1)

Compensación por una lesión deberá ser desaprobada si dicha lesión al empleado es el resultado de:

1. la intención deliberada del empleado de causar dichas lesions;
2. falta intencionada del empleado de no utilizar una guarnición o protección contra accidentes o lesiones que es requerida en conformidad con cualquier estatuto y proporcionadas para el empleado;
3. falta intencionada del empleado para utilizar una razonable y adecuada guarnición y protección voluntariamente provista al empleado por el empleador;
4. violación de descuido del empleado de las normas o reglamentos de seguridad de su empleador o;
5. la participación voluntaria del empleado en peleas o bromas con un compañero de trabajo por cualquier motivo, relacionado con el trabajo o de otro tipo.

Lo anterior no deberá aplicar cuando era razonable bajo la totalidad de las circunstancias para no utilizar dicho equipo, o si el empleador aprobó en el trabajo comprometido en el momento de un accidente o lesión para ser realizado sin dicho equipo.

Enfermedad Coronaria y Derrame Cerebral

La ley no provee compensación por coronaria o enfermedad de la arteria coronaria o lesión cerebro-vascular (por ejemplo, derrame cerebral), a menos que se demuestre que el esfuerzo del trabajo que causó la lesión fue más allá de lo requerido por el trabajo habitual del empleado. Otra excepción es la lesión vascular causada por temperaturas extremas.

Previa Clasificación de Incapacidad/Condición Pre-existente

Compensación por cualquier incapacidad permanente puede ser reducida por la existencia de una clasificación en cualquier incapacidad pre-existente aplicable.

K.S.A 44-501(e): una adjudicación de compensación por incapacidad parcial permanente, incapacidad de trabajo o incapacidad total permanente deberá ser reducida por la cantidad de incapacidad funcional determindada a ser preexistente. Cualquier mencionada reducción no deberá aplicar a incapacidad total temporal, ni deberá aplicar a compensación por tratamiento médico.

K.S.A. 44-501(e)(1): donde beneficios de compensación de trabajadores han sido adjudicados previamente a través de un acuerdo o una determinación judicial administrativa en Kansas, las bases del porcentaje de previo acuerdo o adjudicación deberá establecer conclusivamente la cantidad de incapacidad funcional determinada a ser preexistente. Donde beneficios de compensación de los

trabajadores no han sido previamente adjudicados a través de un acuerdo o determinación judicial o administrativa en Kansas, la cantidad de incapacidad funcional preexistente deberá ser establecida por evidencia competente.

Directrices para Obtener Tratamiento Médico

¿Quién Paga?

Los empleadores son responsables de todo tratamiento médico necesitado para una lesión o enfermedad relacionada con el trabajo. Esto incluye:

- servicios de un médico profesional con licencia;
- cirugías, hospital y otros tratamientos médicos;
- medicamentos, médicos y quirúrgicos suministrados;
- servicios de enfermería;
- muletas y otros aparatos médicos;
- servicios de ambulancia; y
- transporte entre el domicilio del empleado y el lugar de tratamiento médico, sujeto a un mínimo de cinco millas de viaje redondo.

Si un empleador tiene seguro de compensación de trabajadores, la compañia de seguros es requerida a pagar por gastos médicos aplicables. Los empleadores no asegurados sujetos a las leyes de compensación de trabajadores siguen siendo responsables de las facturas médicas de los trabajadores cubiertos.

Los empleadores tienen el derecho legal de elegir al médico del tratamiento. Si un empleado selecciona por sí mismo a un médico no autorizado o que no ha sido acordado con el empleador, el empleador es responsable solamente por los primeros 500 dólares en facturas médicas de dichos médicos seleccionados por el empleado.

Exámenes Ordenados por el Empleador

Después de obtener cualquier atención médica de emergencia necesaria, el empleado deberá someterse a cualquier examen físico razonable ordenado por el empleador. El empleador también puede requerir que el empleado se someta a exámenes de continuo - hasta dos veces al mes, o más seguido si es específicamente ordenado por la División de Compensación de Trabajadores. Los empleados pueden perder su derecho a beneficios que están disponibles si se niegan a someterse a dichos exámenes. Los empleados tienen derecho a conocer los resultados de cualquier examen físico ordenado por el empleador. A petición del empleado, el doctor conduciendo el examen, debe proporcionar al empleado, dentro de un plazo razonable despúes del examen, un informe idéntico al que envió al empleador o compañia de seguros del empleador. Los empleados tienen derecho a tener su propio médico presente, y participar en cualquier examen medico ordenado por el empleador. Si esto no se permite, o si no se proporciona una copia del reporte medico a los empleados, entonces el examen ordenado por el empleador no será admitido como evidencia relacionada con el reclamo.

Fraude y Abuso

La División de Compensación de Trabajadores y el Departamento de Seguros de Kansas tienen unidades dedicadas la investigación de actos fraudulentos o abusivos y práctices que ocurren con respecto a la Ley de compensación de trabajadores. Generalmente pueden ser actos o conductas que se consideran fraudulentas o abusivas descritos como situaciones en que los reclamantes, empleadores o empresas fallan o se niegan a seguir las directrices de la ley de compensación de trabajadores. La ley de compensación de trabajdores aplica a lo siguiente:

- personas reclamando beneficios bajo la Ley de Compensación de Trabajadores;
- los empleadores sujetos a los requisitos de la Ley de Compensación de Trabajadores;
- planes de aseguradoras y grupos mancomunados auto-asegurados, proporcionando cobertura para lesiones relacionadas con el trabajo;
- cualquier persona, empresa, negocio o clínica de salud proporcionando tratamineto para lesiones relacionadas con el trabajo;
- abogados y otros representantes de los empleadores, empleados, aseguradores o de otras entidades involucradas en la administración de la Ley de Compensación de Trabajadores.

Si el director o el fiscal adjunto asignado a la División de Compensación de Trabajdores, tiene causa probable para creer que un acto fraudulento o abusivo o práctica que viola la Ley de Compensación de Trabajadores ha ocurrido, una copia de cualquier orden y todos los informes de investigación y cualquier evidencia en la posesión de la División de Compensación de Trabajadores que se relaciona a dicha ley deberá remitirse al fiscal del condado en el que ocurrió el acto.

Cualquier persona que cree que se ha ocurrido una violación a la ley de Compensación de Trabajadores puede notificar a la División de Compensación de Trabajadores inmediatamente y debe enviar la información relativa a la presunta violación a la División. El director deberá evaluar los hechos en torno a la supuesta violación para determinar en qué medida, si los hubiere, cuales violaciones de la Ley de Compensación de Trabajadores existe. Para obtener más información, llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe un correo electrónico a wcfraud@dol.ks.gov.

Cualquier persona que tenga una queja contra una compañía de seguros, o de otra persona/entidad regulada por Departamento de Seguros de Kansas, en relación con la tramitación de un reclamo de compensación de trabajdores, debe comunicarse con la División de lucha contra fraude en el Departamento de Seguros de Kansas. Las quejas pueden hacerse llamando a los teléfonos (800) 432-2484 o (785) 296-3071, por escrito enviando información a la División de lucha contra fraude a 420 SW 9th St., Topeka, KS 66612, o en el internet en www.ksinsurance.org.

Cobertura y Cumplimiento de Normas

La sección de Cumplimineto supervisa y asiste a los empleadores para asegurar que cumplan con dos requisitos bajo la Ley de Compensación de trabajdores:

1. para proteger los beneficios de compensación de trabajdores para empleados y
2. para presentar informes por escrito de supuestos accidentes de trabajo.

Falta de asegurar beneficios de compensación de trabajdores o de reportar accidentes puede resultar en penas monetarias contra el empleador. Falta de asegurar beneficios de compensación a los trabajdores también puede resultar en la clausura del negocio.

De acuerdo con la ley K.S.A. 44-557, *es...la responsabilidad de cada empleador de hacer o causar que se haga un reporte a el director* de cualquier accidente, relamo o presunto accidente, a cualquier empleado que ocurra en el curso del empleo del trabajador y del cual el empleador o el supervisor del empleador tiene conocimiento, dicho reporte deberá ser hecho sobre una forma que ha de ser preparada por el director**, dentro de los próximos 28 días, después de tener conocimiento, si las lesiones personales que se tuvieron por dicho accidente, son suficientes como para incapacitar total o parcialmente a la persona lesionada de trabajar o de prestar servicios por más de el resto del día, horario o turno en el cual se sostuvieron dichas lesiones*.

Como se indica en K.A.R. 51-9-17, todas las compañías aseguradoras, grupos mancomunados y asegurados por cuenta propia se requiere que usen Intercambio de Datos Electrónicos (EDI por sus siglas en Inglés) para presentar el Primer Reporte de Accidente (FROI, por sus siglas en Inglés) Reportes Subsecuentes de Accidentes (SROI, por sus siglas en Inglés) usando las 3 normas de liberación. Para más detalles contacte la unidad de Tecnología y Estadísticas dentro de la División de Compensación de Trabajadores llamando al los números (785) 296-4000 o (800) 332-0353, o visite nuestro sitio de EDI en: http://www.dol.ks.gov/WorkComp/edinews.aspx.

Cuando el director tiene motivos para creer que un empleador ha incurrido en el conocimiento y falta intencional de asegurar el pago de compensación de Trabajadores a sus empleados, el director deberá emitir y entregar a tal empleador una declaración de los cargos y deberá conducir una audiencia de conformidad con la Ley de Procedimientos Administrativos del estado de Kansas. El empleador puede ser responsable ante el Estado por una pena civil en una cantidad igual a dos veces la prima anual o 25,000 dólares, cualquier cantidad que sea mayor.

*A partir de Enero 1, 2014, la frase "hacer o causar que se haga un reporte al director" significa que el empleador debe reportar a su compañía aseguradora de compensación de trabajadores, cualquier accidente del cual haya sido testigo, reclamado o presunto, con suficiente tiempo para permitir que la aseguradora presente el reporte de accidente a la division dentro de 28 días, como es requerido por la ley K.A.R. 51-9-17.

**La forma requerida para reportar por la Aseguradora a partir de Enero 1, 2014, como se indica en K.A. R. 51-9-17.

El director deberá ordenar a los empleadores de entrar bajo la ley de Compensación de Trabajdores mediante:

1. asegurar y mantener asegurando el pago de dicha compensación con una compañia de seguros autorizada para tramitar las actividades de seguro de compensación de trabajdores en el estado de Kansas;
2. mostrando al director que el empleador porta ese riesgo propio y que es conocido por estar auto-asegurado y mediante proveer prueba al director de la capacidad financiera del empleador de pagar dicha compensación por sí mísmo; o
3. manteniendo una membrecía en un grupo financiero de fondo común que sea cualificado. El costo para proveer dicho seguro o riesgo deberá ser pagado por el empleador y no el empleado.

Para mas información llame a los teléfonos (785) 296-4000 o (800) 332-0353; o envíe su correo electrónico a: wccompliance@dol.ks.gov o visite el sitio en internet www.dol.ks.gov.

Compruebe Cobertura

Usted puede comprobar si una empresa tiene cobertura de compensación de trabajadores en el internet. El sitio proporciona acceso al público a porciones de la información reportada por compañias aseguradoras privadas de compensación de trabajadores para uso del Departamento Laboral de Kansas (KDOL). La exactitud de los datos de cualquier tercer partido no puede ser garantizado por la agencia y KDOL no es responsable de la información de cobertura disponible a través de este enlace.

Para obtener ayuda adicional para verificar la cobertura de compensación de trabajdores en Kansas, llamar a Cobertura y cumplimiento de normas de la División de Compensación de Trabajadores al (785) 296-4000.

Servicios de Salud y Seguridad

La prevención de accidentes y seguridad en el lugar de trabajo es un elemento clave de la ley. Este requisito fue diseñado para reducir reclamos/pérdidas, lo que mantendría bajas las primas para los empleadores. Debido a que las tarifas se basan en las pérdidas, la prevención de accidentes de los empleados, a través de medidas elevadas de seguridad, es una de las mejores maneras en que los empleadores pueden ayudar a mantener bajas las tasas de interés.

De acuerdo con la ley, las compañias de seguros y planes de grupos financieros deben proporcionar programas de prevención de accidente cuando sea solicitado por sus asegurados. Aviso de tales programas de prevención de accidentes debe aparecer en la portada de todas las pólizas emitidas después de julio de 1993.

Programas Ofrecidos por el Departamento Laboral de Kansas

Consulta: ofrece asistencia a los empleadores del sector privado en las evaluaciones del programa de salud y seguridad. Los consultores ofrecen asesoría en el reconocimiento, evaluación y control de riesgos laborales. Asistencia con la iniciación y el desarrollo del programa está disponible. Entrenamiento, formal e informal, es realizado en todos las áreas de salud y seguridad. Todos los servicios son sin costo al cliente.

Cumplimiento del Sector Público: supervise al sector público - ciudades, condados, agencias estatales y distritos escolares - mediante la realización de auditorías de cumplimiento bajo el artículo K.S.A. 44-636 o K.S.A. 44-575(f). Se identifican los riesgos laborales y se evalúan los elementos del programa. Los riesgos deben ser disminuidos dentro de 60 días. También se realizan investigaciones de quejas de empleados, accidentes leves y fatalidades.

Prevención de Accidentes: evalúa las compañias de seguros y planes de auto-seguro de grupo financiero para garantizar que están ofreciendo y proporcionando servicios de seguridad y salud sin costo para sus asegurados, como es requerido por la ley. La calidad y cantidad de estos servicios son evaluadas por consultores capacitados mediante revisar directamente los registros de la compañia de seguros y ponerse en contacto con aquellos que han solicitado y han recibido los servicios.

Asistencia en Prevención de Accidentes está disponible mediante correspondencia electronica AccidentPrevention@dol.ks.gov. También puede encontrar información en linea en: www.dol.ks.gov/Safety/accident.aspx.

Conferencia de Salud y Seguridad: la Conferencia annual de Salud y Seguridad de Kansas reúne a los representantes del sector industrial, académico, proveedor y del Gobierno. La Conferencia se lleva a cabo sin la ayuda de otros y trata de abordar las cuestiones relevantes de seguridad en una variedad de talleres y presentaciones.

Asistencia para salud y seguridad en el lugar de empleo está disponible llamando al (785) 296-4386 o envío de correo electrónico a **indsafetyhealth@dol.ks.gov.** Usted también puede encontrar información en el internet bajo Seguridad Laboral visitando **www.dol.ks.gov**.

Servicios de la Sección Ombudsman

La División de Compensación de trabajdores de Kansas estableció una Sección de Asesoramiento al Reclamante en el año de 1978. En 1993 la Legislatura siguió una tendencia nacional y, por ley, crearon el programa Ombudsman. La legislación de reforma de la compensación de los trabajadores en 1993 se ordenó una definición más amplia para la Sección de Consejeros para Reclamantes, facilitando el llevar un papel más activo para ayudar a todos los participantes a entender sus derechos y sus responsabilidades bajo la ley de Compensación para Trabajadores.

La División emplea personal de tiempo completo que se especializan en ayudar a los trabajadores lesionados, los empleadores y profesionales en seguros con información de reclamos y problemas derivados de accidentes de trabajo y enfermedades. El ombudsman actúa de manera imparcial y está disponible para proporcionar a los participantes información acerca de asuntos actualizados dentro del sistema de compensación de trabajadores. Por ejemplo, el ombudsman tiene información actualizada sobre cambios legislativos o modificaciones debido a decisiones tomadas por la Junta de compensación de trabajdores o del sistema legal. La sección de ombudsman también puede ayudar con temas específicos o reclamos actuales de compensación de trabajadores.

Ayudando a los trabajadores lesionados con:

- Proporcionando información general
- Obteniendo tratamiento médico
- Beneficios no pagados o no pagados oportunamente
- Beneficios médicos no pagados
- Cálculos de beneficios
- Notificación oportuna del empleador
- Procedimientos para la solicitud de una audiencia
- Obtención de beneficios de los sobrevivientes
- Resolución informal de disputas
- Asistencia de medicación
- Interpretación para los trabajadores de habla hispana

Ayudar a los empleadores/compañias de seguros:

- Proporcionando información general
- Exhibir el aviso de Compensación de Trabajadores (K-WC 40-A)
- Proporcionando información requerida a los trabajadores lesionados (K-WC 27-A/K-WC 270-A)
- Presentación oportuna del los reportes de accidentes
- Pago oportuno y adecuado de los servicios médicos
- Información de elecciones
- Asistencia con requisitos del beneficio por fallecimiento
- Resolución de disputa informal
- Asistencia con los trabajadores de habla hispana
- Capacitación del personal de empleador en cuestiones de compensación de trabajdores
- Visitas de asistencia práctica a los sitios de trabajo

Asistencia de un Ombudsman está disponible ya sea en persona o llamando al (785) 296-4000 o al (800) 332-0353. Usted también puede enviar un correo electrónico a **wc@dol.ks.gov.** Además, los formularios están disponibles para su descarga en **www.dol.ks.gov**.

Unidad de servicios al empleador

Para asistencia técnica y presentaciones y capacitación para empleadores, llame al (785) 296-4000 o (800) 332-0353, o escriba al correo electrónico **wcemployerservices@dol.ks.gov**.

Mediación

La mediación fue legislativamente creada en 1996 (K.S.A. 44-5,117) y puede ser utilizada en cualquier momento durante el proceso de compensación de trabajadores. El estatuto fue enmendado en 1998 para permitir la mediación por video conferencias. La mediación no es obligatoria o un requisito previo para una audiencia y puede ser utlilizado en cualquier tiempo durante el proceso de compensación del trabajador. Los asuntos que se pueden mediar no se limitan a cuestiones de tratamiento médico o beneficios de incapacidad total temporal.

¿Qué es la Mediación?

La mediación es un medio de resolver los conflictos en un informal y no contencioso ambiente. El las partes en una controversia utilizan un tercer partido neautral para facilitar la discusión. El mediador no tiene ninguna autoridad haciendo decisiones o interés en el resultado del conflicto. El trabajo del mediador es ayudar a las partes involucradas para identificar las cuestiones en disputa y el establecimiento de objectivos comunes. La clave de la mediación es que permite las partes involucradas a trabajar a través de su disputa y crear sus propios acuerdos.

¿Quiénes son los Mediadores?

Los mediadores son empleados de la División de Compensación de Trabajadores que han recibido especial capacitación en el proceso de mediación. Los mediadores utilizados por la División de compensación para trabajadores cumplen o superan los requisitos establecidos por K.S.A. 5-501 y enmiendas al mismo y cualquier regla pertinente de la Corte Suprema de Kansas en conformidad con el artículo K.S.A. 5-510 y enmiendas. Los mediadores reciben capacitación en técnicas de resolución de conflictos, neautralidad, preparación de acuerdos, ética, desempeño como mediador, habilidades de comunicación, evaluación de casos y las leyes que rigen la mediación.

Representación y Asistencia

Cualquiera de los participantes podrá estar representado por un abogado en esta conferencia de mediación o podrá solicitar asistencia de la Sección Ombudsman/Consejeros de Reclamos. La ausencia de un abogado durante el proceso no significa que representación legal no puede obtenerse posteriormente si la disputa no se resuelve en este contexto informal.

Para obtener información adicional o para programar una conferencia de mediación, llame al (785) 296-4000 o (800) 332-0353. Escribir a la Sección de Mediación, Departamento Laboral de Kansas, División de Compensación de Trabajadores, 401 SW Topeka Blvd, Topeka, KS 66603-3182. Puede enviar correo electrónico a **wcmediation@dol.ks.gov.**

Servicios Médicos

La función principal de la sección de Servicios Médicos es la administración de la programación de honorarios médicos. El programa de honorarios es actualizado y revisado anualmente para promover la contención del costo de salud, y todavía asegurar la disponibilidad de tratamiento necesario y cuidado para los empleados lesionados.

La sección de Servicios Médicos está disponible para actuar como un enlace entre los proveedores de atención médica, empleadores, empleados, aseguradoras, grupos financieros con fondo común o empresas auto-aseguradas. Además, la sección conduce audiencias informales para ayudar en la resolución de reclamos médicos en disputa y pagos relacionados que envuelven a proveedores de atención médica.

Para obtener ayuda para resolver los problemas relacionados con interpretación de programación de tarifa, disputas de pago, etc., contacte la sección de servicios médicos al (785) 296-4000 o fax (785) 296-0025.

Rehabilitación Vocacional

Rehabilitación profesional podrá facilitarse a opción del empleador o de la aseguradora del empleador. La experiencia general ha demostrado que cuanto mayor sea el lapso de tiempo que el empleado esté fuera del trabajo en recuperación de una lesión, mayor será la probabilidad de que un empleado necesitará rehabilitación vocacional para reanudar trabajo adecuado a una remuneración comparable.

Si el empleador o la compañia de seguros no eligen proporcionar rehabilitación profesional, el empleado puede pedir al administrador de rehabilitación una referencia con un proveedor de dichos servicios a expensas del empleado. El empleado también puede solicitar una referencia a la División de Servicios de Rehabilitación en el Departamento de Servicios de Rehabilitación en el Departamento por Niños y Familias.

Para obtener ayuda con la rehabilitación profesional, póngase en contacto con la oficina del administrador de rehabilitación en la División de Compensación de Trabajadores (800) 332-0353, (785) 296-4000 o envíe un correo electrónico a wcrehab@dol.ks.gov.

Departamento Laboral de Kansas
División de Compensación de Trabajadores

Departamento de Seguros de Kansas

POLICY NUMBER: 08 WEC AP8931

Our President and Secretary have signed this policy. Where required by law, the Information Page has been countersigned by our duly authorized representative.

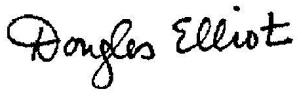
Lisa Levin, Secretary

Douglas Elliot, President

POLICY NUMBER: 08 WEC AP8931
NAME OF INSURER: Twin City Fire Insurance Company

Our President and Secretary have signed this policy. Where required by law, the Information Page has been countersigned by our duly authorized representative.

Kevin Barnett, Secretary



Douglas Elliot, President

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY COPYRIGHT PAGE

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY SIGNATURE PAGE

POLICY NUMBER: 08 WEC AP8931
NAME OF INSURER: Twin City Fire Insurance Company

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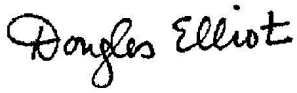
Kevin Barnett, Secretary



Douglas Elliot, President

INSTRUCTIONS

EMPLOYEE'S CLAIM FOR WORKERS' COMPENSATION BENEFITS

As of January 1, 1990, California employers are required by law to furnish a claim form to an injured worker within one working day of knowledge of a work-related injury or illness (other than First Aid). While it is mandatory for the employer to furnish the claim form to the employee, **it is not mandatory for the employee to complete it.**

The employer should complete sections 9-17, with the exception of section 13 (which reads, "Date employer received claim form"). This is to be completed **after** the claimant has completed his or her portion of the claim form and returned it to you, at which time section 13 should be **immediately** filled out or date stamped.

Penalties can be invoked if employers fail to provide an injured employee an EMPLOYEE'S CLAIM FOR COMPENSATION BENEFITS form or if employers fail to report the claim to the workers' compensation insurance carrier.

DO NOT DELAY REPORTING A CLAIM TO THE HARTFORD:

Whether or not the employee completes the EMPLOYEE'S CLAIM FOR WORKER'S COMPENSATION BENEFITS, please contact The Hartford's **LossConnect (1-800-327-3636)** to report every occupational injury or illness which results in lost time beyond the date of the incident or requires medical treatment beyond First Aid.

Form WC 55 00 11 D Printed in U.S.A.

AN IMPORTANT NOTICE TO WORKERS' COMPENSATION POLICYHOLDERS

The control of workplace accidents and injuries should be among the highest priorities of your firm. Each accident wastes precious human and financial resources, and introduces inefficiencies into your operations. From a practical standpoint, the control of accidents, and their inevitable costs, simply makes good business sense. An effective loss prevention/ risk engineering program can save you money and aggravation, can positively impact your loss experience (and thus your premium), and most importantly, can help you maintain solid control of your operations. As a service to you, our valued customer, the Risk Engineering Department of The Hartford can assist you in establishing time-proven and cost effective loss prevention and risk engineering strategies. This folder outlines many of the services available to you, and provides a mechanism for you to request them. If you would like additional information or assistance, please complete and return the reply portion to us; or, contact your independent agent.

A WORD ABOUT OREGON-OSHA

As an Oregon employer you are required by the Oregon Safe Employment Act (ORS 654.001 to 654.295 and 654.991) to provide employees with a safe and healthful workplace. By working to prevent injuries, illnesses and other economic losses, your company and employees can prosper.

INSURER SAFETY PROGRAMS

To help you reduce your premium, your workers' compensation insurer must help you reduce the risk of injuries in your workplace. It is required by law to offer occupational safety and health loss prevention services to you, **at no additional cost**. These include on-site safety and health surveys when you request them.

On an annual basis your insurer is required to:

- **o** Inform you about its occupational health and safety loss prevention programs;
- **o** Offer to provide an on-site evaluation of your loss prevention needs;
- **o** Provide assistance in evaluating records that may be pertinent to your firm's injury and illness experience;
- **o** Explain the Oregon Safe Employment Act and rules that apply to your particular place of employment;
- **o** Provide an evaluation of workplace design, layout and operation, and assistance with job-site modifications utilizing an ergonomic approach;
- **o** Provide assistance in evaluation and improving an employer's safety management practices;
- **o** Provide assistance in identifying health and safety training needs and available resources; and
- **o** Offer to provide follow-up services for evaluating the effectiveness of the service provided.

The Hartford will provide free of charge an on-site evaluation of your loss prevention needs. To avail yourself of this service, or any other risk engineering needs you may have, contact The Hartford by writing to:

The Hartford

Risk Engineering

One Hartford Plaza

Hartford, CT 06155

Mail Drop: Cogswell - 1st floor

e-mail: riskengineering@thehartford.com

or by calling 866-586-0467

You have the right to make a complaint to the OR-OSHA Division if we fail to respond to your request for loss prevention services, or we otherwise fail to provide services as offered or required. You may contact Oregon-OSHA, Insurer Programs, 16760 SW Upper Boones Ferry Road, Suite 200,Tigard, OR 97224, or (503) 229-5910.

Your insurer must also provide you with a health and safety loss prevention plan if you have been placed in the "designated employer" category by OR-OSHA. These plans are designed to help you develop a safer and healthier workplace. For further information, contact OR-OSHA's Insurer Program Coordinator at (503) 229-5910.

AN IMPORTANT NOTICE TO WORKERS' COMPENSATION POLICYHOLDERS

PROTECT YOURSELF

To protect yourself as a workers' compensation insurance consumer, take these steps:

- **Shop around for your insurance. Compare costs:** Although the base premium is the same, the overhead charged by insurers ranges from 15 percent to over 50 percent. Also, look beyond costs. Find out what type of assistance the insurer will give if one of your workers is injured. Does the insurer have a good customer service record?
- **Look at all the factors that make up your rates and premium.** Periodically review all details of your policy, including classifications assigned your employees, payroll to be used, claims, reserves, audits and billings. If you believe your insurer is wrong, check with your agent, NCCI, or the Department of Consumer and Business Services, and, if necessary, appeal the insurer's action.
- **Support "fair reporting" for equitable rates.** The information used to determine your merit or experience rating and classification rate revisions originates with you and your business competitors. Therefore, it is important to promote full, proper reporting of payrolls.
- **Inquire about preferred group programs.** Many insurers offer reduced group pricing to members of trade associations. Ask your insurer and trade association about this type of program. Many smaller employers receive substantial benefits from these programs, such as lower mass-marketed pricing and outstanding safety engineering and loss prevention services.
- **Ask your insurer about medical cost reimbursement.** Employers can reimburse up to $2300 of medical service provider costs on nondisabling claims. These costs are not charged to the employer's experience. Ask your insurer or agent to explain the program and how it could affect your rates.

HOW DO I GET HELP?

Contact your insurance agent or representative with any questions you have about choosing policies, interpreting your policy, and getting help to make your workplace safer. If it is necessary to go beyond your agent, contact your insurance company directly.

If your insurer does not provide the information or assistance you need, several organizations are available to help you.

For questions on occupational safety and health, contact:

Oregon Occupational Safety and Health Division

Department of Consumer and Business Services

350 Winter Street NE, Room 430

Salem, OR 97309-0405

(503) 378-3272 or toll free at 1-800-922-2689

For questions on your policy or pricing, contact:

Division of Financial Regulation

Department of Consumer and Business Services

350 Winter Street

Salem, OR 97301-3883

(503) 947-7984

For questions on the rating system, contact:

The National Council on Compensation Insurance

1 Lincoln Center

10300 SW Greenburg Road, Suite 550

Portland, OR 97223

(503) 892-8919 or toll free at 1-800-622-4123

PENNSYLVANIA WORKERS' COMPENSATION REFORM

Act 57 of the Pennsylvania law lengthens the period of time during which you may require an injured employee to seek treatment from a health care provider designated by the employer. Effective August 23, 1996, the period was lengthened from 30 days to 90 days after the date of the first visit to a designated health care provider.

Under the terms of the law, you MAY NOT DIRECT an injured worker to a health care provider during such 90 day period UNLESS first obtaining written acknowledgment from the employee indicating that the employee has been informed of and understands his or her rights and obligations under the provisions of section 306 (F.1)(1)(1) of the Workers' Compensation Act. If you fail to obtain such written acknowledgment, an injured employee is entitled to treatment from a medical care provider of his or her choice. The Hartford will be responsible for paying the cost of such treatment. However, because such treatment will be more expensive, you should be advised that it could adversely impact your future insurance cost.

Attached is a sample of a FORM WHICH WE ENCOURAGE YOU TO USE to inform employees of their rights and obligations under the law and which can be used to obtain their written acknowledgment of such rights and responsibilities.

IF YOU HAVE NOT ESTABLISHED A PANEL OF PHYSICIANS, WE CAN BE OF ASSISTANCE. The Hartford currently utilizes FIRST HEALTH as their medical network for the state of Pennsylvania. FIRST HEALTH is one of the nation's largest preferred provider organizations offering a network of Workers' Compensation focused providers and comprehensive array of services, industrial medical clinics and work hardening centers. You may contact The Hartford's Network Referral Unit directly at 1-800-327-3636, option 4, to obtain a list of treating physicians.

We appreciate your cooperation and encourage you to utilize our Hartford LossConnect reporting system. (1-800-327-3636) to report your losses with 24 hours.

IMPORTANT NOTICE

This Notice shall service to advise you of your rights and responsibilities under the Pennsylvania Workers' Compensation Act.

If you sustain a work-related injury requiring medical treatment, you are required to first treat with a doctor who is on a list of six (6) providers identified below. You are required to treat with that provider for ninety (90) days from the first visit. However, if invasive surgery is recommended by the designated physician, then you are allowed a second opinion by a physician of your choice. If the second opinion differs from the first, you have the right to determine which course of treatment to follow, provided that the second opinion provides a specific and detailed course of treatment. If you choose to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the second opinion visit. Treatment with your own medical provider in violation of the above may result in your medical bills being unpaid for the prescribed period. Upon expiration of the prescribed period, if you select a medical provider not on the panel below, you must notify your employer of your choice of providers within five (5) days of the first visit or risk non-payment of those medical bills until proper notice is given. Your employer's approved providers are:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

The name of your employer's insurance carrier is:

The Hartford
P.O. Box 4771
Syracuse, NY 13221
1-877-469-9222

Please sign where indicated to verify that you understand the rights and responsibility outlined in this Notice.

I, _____,
have read the above and understand the rights
and responsibilities explained to me therein.

_____ _____

Signature of Employee/Date Witness/Date

Reporting a Work-Related Injury is Time Sensitive!

Call The Hartford's LossConnect immediately to report a claim.

1-800-327-3636

Available 24 hours a day, 365 days a year.

The Benefits of Timely Loss Reporting:

Research has shown that faster loss reporting significantly affects loss costs. The sooner we are notified, the sooner we can investigate the accident and coordinate with you, the injured employee, and the medical team to ensure the fastest possible return to health and work.

The Effect of Timely Reporting on Controlling the Cost of Your Loss:

Average Loss for Closed Claims (Accident Years 2002-2005)	
Report Lag in Days	**Percent Change in Loss Costs Compared to First Week Report**
Incident Day	-6%
Week 1	0%
Week 2	13%
Week 3 or 4	16%
1 Month or Later	24%

Statutory requirements also necessitate the prompt initial reporting of the accident causing injury or death. Failure to comply may result in a fineable offense by the State.

Information You'll Need

Company Information
- Account Number
- Location Code (if applicable)
- Parent Company (or program name)
- Policy Number

Worker Information
- Name, DOB, Address, Phone
- Social Security Number
- Age, Gender
- Marital Status, Number of Dependants
- Hire Date, Years in Current Position
- Wage Information

Incident Information
- Type of injury (burn, cut, etc.)?
- Exact body part injured?
- What caused the accident?
- Any reason to question the injury?
- Any witnesses?
- Address where injury occurred?
- Where was the injured employee treated? (Provide name, address, phone of medical provider.)
- When was the accident reported to you and by whom (date, time)?

Network Providers

A listing of more than 400,000 network providers qualified to treat work-related injuries is available online at www.talispoint.com/hartext or by calling our Network Referral Unit at 1-800-327-3636 (select 4 at the prompt). Since network referrals are often impacted by state specific rules, please call to learn how to maximize our network capabilities on behalf of your employees.

Form WC 66 03 84 Printed in U.S.A.

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Information You'll Need

Company Information

- Account Number
- Location Code (if applicable)
- Parent Company (or program name)
- Policy Number

Worker Information

- Name, DOB, Address, Phone
- Social Security Number
- Age, Gender
- Marital Status, Number of Dependants
- Hire Date, Years in Current Position
- Wage Information

Incident Information

- Type of injury (burn, cut, etc.)?
- Exact body part injured?
- What caused the accident?
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- Any witnesses?
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****The First Report of Injury (Form WCB-1) must be filed within 7 days of the employer's knowledge of incapacity of one day or more. A civil penalty may be assessed not to exceed $100 for each violation. The State Board may also assess a penalty up to $1,000 for individual and $10,000 for corporation for willful violation, fraud, or intentional misrepresentation.***

Reporting a Work-Related Injury is Time Sensitive!

Call The Hartford's LossConnect immediately to report a claim.

1-800-327-3636

Available 24 hours a day, 365 days a year.

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- Name, DOB, Address, Phone
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- Age, Gender
- Marital Status, Number of Dependants
- Hire Date, Years in Current Position
- Wage Information

Incident Information

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- Exact body part injured?
- What caused the accident?
- Any reason to question the injury?
- Any witnesses?
- Address where injury occurred?
- Where was the injured employee treated? (Provide name, address, phone of medical provider.)
- When was the accident reported to you and by whom (date, time)?

Network Providers

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Employers must report the claim to their insurers no later than 5 days after notice or knowledge of any claim or accident that may result in a compensable injury (656.262(3)(a)). The employer's knowledge date is the earliest of the date the employer first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility.

IMPORTANT NOTICE

STATE OF GEORGIA WORKERS' COMPENSATION REQUIREMENTS

Thank you for selecting The Hartford for your Workers' Compensation insurance. We are pleased to have you as one of the 1 million plus business owners who have selected The Hartford to help protect their businesses and their employees.

You are receiving this Notice to help you comply with requirements of Georgia's State Board of Workers' Compensation. Specifically, you are obligated to post a Physician Panel and Employee Bill of Rights in a conspicuous place. These required documents, explained below, immediately follow this Notice.

PHYSICIAN PANEL
This is a list of physicians from whom an injured worker must seek care if they are injured on the job. The providers on the Physician Panel are members of The Hartford's network of physicians in your area, all of whom specialize in treating work-related injuries. Treatment outside the Physician Panel is generally not a covered benefit.

At The Hartford we focus on an injured worker's abilities, and work to identify transitional duties to help keep your employee productive and involved. Even part-time work or a temporary assignment can provide motivation to the employee and productivity for you. In addition, when treatment is provided by a physician in our network, we're able to help control claim costs, which could save you money on future Workers' Compensation premiums.

If you prefer to create a custom panel of network physicians or have questions regarding the Physician Panel, please contact The Hartford at 800-327-3636, and select option 4.

EMPLOYEE BILL OF RIGHTS
This document details an employee's rights and your obligations if an employee is injured on the job.

Please post the Physician Panel and Employee Bill of Rights immediately and ensure employees are aware of their rights and obligations.

For over a century, The Hartford has set the standard for injured worker care. Thank you again for choosing The Hartford.

IMPORTANT NOTICE
GEORGIA WORKERS' COMPENSATION INSURANCE
BENEFITS DEDUCTIBLE ELECTION FORM

Georgia Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for Indemnity and/or Medical benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
( )	$ 100	0.7%	0.6%	0.4%	0.4%	0.3%	0.1%	0.1%
( )	200	1.3%	1.1%	0.9%	0.7%	0.5%	0.3%	0.3%
( )	300	1.8%	1.5%	1.3%	1.0%	0.7%	0.4%	0.4%
( )	400	2.3%	1.9%	1.6%	1.3%	0.9%	0.6%	0.6%
( )	500	2.7%	2.3%	2.0%	1.5%	1.1%	0.7%	0.7%
( )	1,000	4.5%	3.8%	3.4%	2.6%	1.9%	1.3%	1.2%
( )	1,500	5.8%	4.9%	4.4%	3.4%	2.6%	1.8%	1.6%
( )	2,000	6.8%	5.9%	5.2%	4.2%	3.1%	2.2%	2.0%
( )	2,500	7.8%	6.7%	5.9%	4.7%	3.6%	2.5%	2.4%

All indemnity and/or medical claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return this form to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

DEDUCTIBLE NOTICE OF ELECTION TO ACCEPT TEXAS WORKERS COMPENSATION BENEFITS

Texas law permits an employer to obtain Workers' Compensation insurance with a deductible. The deductible applies to benefits payable under Texas Workers' Compensation Law. The insurance applies only to benefits in excess of the deductible amount. The deductible applies separately to each accident or disease regardless of the number of people who sustain injury by such accident or disease or claim or medical-only claim. The deductible plans have been explained to me. Premium reductions are determined based on the deductible selected, and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

You are not required to choose a deductible. If you do choose one, your insurance company will pay the deductible amount for you, but you must reimburse the insurance company within 30 days after they send you notice that payment is due. If you fail to reimburse the company, they may cancel the policy, upon ten days written notice, and any resulting premium may be applied to the deductible amount owed.

If a deductible amount is desired, please indicate below.

( ) Yes, I want a deductible of: (select only one)

1 $ per accident

2. $ per claim

3. $ per medical-only claim

applied to benefits payable under the Texas Workers' Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement

(monthly, quarterly or other)

( ) No, I do not want a deductible applied to benefits payable under the Texas Workers' Compensation Law

( ) Yes, I do want a deductible policy, but am unable to obtain for the following reason:

CAMUNDA INC

Employer Name (print or type)

Date

08 WEC AP8931

Signature and Title

Policy Number

IMPORTANT NOTICE

COLORADO WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY DEDUCTIBLE ELECTION FORM

Colorado Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only. There are nine "Per Claim" deductible options available. They are:

( ) NONE
( ) $ 500
( ) 1,000
( ) 1,500
( ) 2,000
( ) 2,500
( ) 5,000
( ) 10,000
( ) 13,500
( ) 15,500
( ) 16,000
( ) 16,500
( ) 17,000
( ) 17,500
( ) 18,000
( ) 18,500

All medical and indemnity claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you have any questions, or desire one of these deductible amounts to apply to your coverage, please call your Agent for a quote. This offer is valid for thirty days after the effective date of the policy with which this notice is enclosed.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

Form WC 66 01 49 J Printed in U.S.A.
Process Date: 07/02/22 **Policy Expiration Date:** 08/11/23

MASSACHUSETTS BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect a medical and indemnity deductible, and your policy is being renewed effective on or after January 1, 1997, you must make your election before the effective date of your policy, otherwise at the next renewal of your policy.

( ) $ 500	**( ) $ 2,500**
( ) $ 1,000	**( ) $ 5,000**
( ) $ 2,000	**( ) Do Not Elect**

( ) $ 2,500 with Aggregate	**( ) Do Not Elect**

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

OKLAHOMA WORKERS COMPENSATION MANDATORY OPTIONAL DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires carriers issuing a policy under the Administrative Workers' Compensation Act (AWCA) to offer deductibles, optional to the policyholder, for benefits payable under the AWCA.

This form is applicable to the optional deductibles required by 85A O.S. Section 95 and OAC 365:15-1-3.1.

All five deductible options set forth below must be fully disclosed to the prospective policyholder in writing. The policyholder is not required to select a deductible option, but if the policyholder chooses a deductible, the policyholder may choose only one combined (medical benefits and indemnity claims) deductible amount. Medical only claims are included in the eligibility for a combined medical and indemnity deductible. The maximum combined deductible, including medical benefits and indemnity claims, will be $5,000 per claim. Please carefully review the requirements for the deductible options outlined below.

DEDUCTIBLE OPTIONS

The combined optional deductible amounts are:

- **o** $1,000
- **o** $2,000
- **o** $3,000
- **o** $4,000
- **o** $5,000

EMPLOYER OBLIGATIONS IF A DEDUCTIBLE OPTION IS SELECTED

If the applicant employer chooses a deductible, the carrier must pay compensable claims to the person or medical providers entitled to the benefits conferred by the AWCA, and obtain reimbursement from the insured employer for the applicable deductible amount.

WARNING: The insured employer must reimburse the carrier within 60 days of a written demand. If the insured employer fails to reimburse the carrier within 60 days, the carrier may seek to recover the full amount of the claim from the insured employer. In addition, the nonpayment of deductible amounts must be treated in the same manner as nonpayment of premium for purposes of cancellation of the policy.

EXPERIENCE RATING MODIFICATION

Benefits paid by the insured employer under a deductible may not be treated as benefits paid so as to harm the experience rating of the employer, and will not be charged against the experience of the employer in accordance with OAC 365:15-1-3.1(d).

ACCEPTANCE/REJECTION

☐ Yes, I have read the optional deductible information summarized above and want the following deductible amount to apply to claims under the AWCA. I understand that this deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

MEDICAL AND INDEMNITY

- ☐ $1,000
- ☐ $2,000
- ☐ $3,000
- ☐ $4,000
- ☐ $5,000

ACCEPTANCE/REJECTION

- ☐ Yes, I understand that I am responsible for reimbursing my insurance company for the amounts of any deductible it pays.
- ☐ No, I do not want the optional deductible described in this form.

NAMED INSURED _____

ADDRESS _____

TITLE _____

SIGNATURE _____

DATE _____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

IMPORTANT NOTICE

NEW YORK WORKERS' COMPENSATION INSURANCE BENEFITS DEDUCTIBLE ELECTION FORM

New York Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for benefits and applies separately to each claim.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

[ ] 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

[ ] 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

		A	B	C	D	E	F	G
	$ 100	0.3%	0.2%	0.2%	0.1%	0.1%	0.1%	0.1%
	$ 200	0.5%	0.4%	0.4%	0.3%	0.3%	0.1%	0.1%
	$ 300	0.8%	0.6%	0.5%	0.4%	0.3%	0.2%	0.2%
	$ 400	0.9%	0.7%	0.6%	0.5%	0.5%	0.3%	0.2%
	$ 500	1.1%	0.8%	0.8%	0.6%	0.5%	0.3%	0.3%
	$1,000	1.8%	1.4%	1.3%	1.0%	1.0%	0.6%	0.5%
	$1,500	2.3%	1.9%	1.7%	1.4%	1.3%	0.8%	0.6%
	$2,000	2.8%	2.3%	2.2%	1.7%	1.6%	1.0%	0.8%
	$2,500	3.3%	2.7%	2.6%	2.1%	1.9%	1.2%	1.0%
	$5,000	5.1%	4.4%	4.2%	3.5%	3.3%	2.1%	1.7%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return this form to:
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

IMPORTANT NOTICE

RHODE ISLAND WORKERS' COMPENSATION INSURANCE
MEDICAL AND INDEMNITY BENEFITS DEDUCTIBLE ELECTION FORM

Rhode Island Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for medical and indemnity benefits only.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
HAZARD GROUP

			A	B	C	D	E	F	G
( )	$	250	1.6%	1.1%	1.0%	0.8%	0.7%	0.5%	0.5%
( )	$	500	2.8%	2.1%	1.8%	1.5%	1.2%	0.9%	0.8%
( )	$	1,000	4.5%	3.4%	3.1%	2.5%	2.1%	1.6%	1.5%
( )	$	2,500	8.0%	6.3%	5.7%	4.8%	4.0%	3.3%	3.0%
( )	$	5,000	11.8%	9.7%	8.9%	7.6%	6.5%	5.4%	4.8%

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

Return to
Issuing Office: THE HARTFORD BUSINESS SERVICE CENTER
Address: 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

IMPORTANT NOTICE

MAINE WORKERS' COMPENSATION INSURANCE
INDEMNITY AND MEDICAL DEDUCTIBLE ELECTION FORM

Maine Workers' Compensation law permits an employer to purchase workers' compensation insurance with a deductible. The deductible is for indemnity benefits or medical benefits. Indemnity deductibles apply separately to each claim and medical deductibles apply to each accident.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject any deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect one of the following deductibles to be applied to benefits under my workers' compensation insurance policy and each subsequent renewal. The premium reduction to be applied is shown below.

PREMIUM REDUCTION
Hazard Group

			A	B	C	D	E	F	G
Indemnity	**( )**	**$1,000**	1.4%	1.1%	1.1%	1.0%	0.8%	0.7%	0.6%
	( )	**$5,000**	5.2%	4.3%	4.0%	3.7%	3.3%	2.8%	2.4%
Medical	**( )**	**$ 250**	2.6%	2.1%	1.9%	1.3%	1.0%	0.7%	0.7%
	( )	**$ 500**	4.3%	3.6%	3.3%	2.3%	1.8%	1.3%	1.3%

The $500 medical deductible can only be chosen if you qualify for experience rating.

All claims shall be paid by the company. In such case, the law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**
Issuing Office THE HARTFORD BUSINESS SERVICE CENTER 3600 WISEMAN BLVD SAN ANTONIO TX 78251		

IMPORTANT NOTICE

FLORIDA WORKERS' COMPENSATION INSURANCE

BENEFITS DEDUCTIBLE ELECTION FORM

Florida Workers' Compensation Law permits an employer to purchase workers' compensation insurance with a state authorized $2,500 deductible plan. Any amounts paid by you shall not apply to your experience rating. This option is not available if your policy is retrospectively rated. There is no premium reduction under this deductible option.

Please check the option which you have elected and return this form to the company prior to the effective date of your coverage.

( ) 1. I reject this deductible option and elect that the company pay all benefits due under my policy.

( ) 2. I elect this deductible option to be applied to Indemnity and/or Medical benefits under my workers' compensation insurance policy and each subsequent renewal.

All indemnity and/or medical claims shall be paid by the company. The law requires that you reimburse the company for any deductible amounts so paid.

If you do not return this form promptly to the company, it will be construed to mean that we should pay in full all benefits due under your policy with no contribution on your part.

If you have any questions, please call your Agent.

Policy Number 08 WEC AP8931		
Employer Name CAMUNDA INC	**Date**	**Signature and Title**
Agent Name MARSH & MCLENNAN AGENCY LLC	**Date**	**Signature**

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

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM (Form 09-01A)

Name of Employer: _____

Date Program Implemented: _____

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____
B. Phone No.: ( ) _____
C. Address: _____

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

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and I attest to the accuracy of the information submitted.

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

WORKERS' COMPENSATION SELECTION OF DESIGNATED MEDICAL PROVIDER DISCLOSURE STATEMENT

If you select two Designated Medical Providers meeting the following qualifications, a premium credit will be applied to your policy. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

A qualified Designated Medical Provider is a medical provider, who:

1) **Has a knowledge of work injuries;**
2) **Is knowledgeable of fee schedules;**
3) **Is decisive on medical-maximum-improvement determinations;**
4) **Communicates with you, the employer on such issues as case management and wellness programs;**
5) **Is knowledgeable of the employers operations.**

The names of the providers must be posted and well publicized by you, the employer.

** SIGN AND RETURN **

I am aware of the availability of a premium credit of 2.5%, if I select two qualified Designated Medical Providers. For policies eligible for this credit as well as schedule rating, the combination of the 2.5% credit and the schedule modification cannot exceed +/-25%.

Insured Signature _____

Policy Number 08 WEC AP8931

Issuing Office THE HARTFORD BUSINESS SERVICE CENTER
Issuing Office Address 3600 WISEMAN BLVD
SAN ANTONIO TX 78251

Utah and Virginia Drug Free Workplace Credit

This form attests to your agreement to implement and/or continue to monitor the drug free workplace program you have established throughout the policy period. By signing this form, you agree to continue the following activities or notify us of your intent to discontinue such practices.

- Provide notice to employees and job applicants including a written statement containing the policy on employee drug use, type of drug testing that may be required, actions that can be taken if the test result is positive, consequences of refusing to submit to a drug test, and a list of all drugs for which you will test.

- Educate employees and supervisors about the drug free program in place.

- Require discharge or discipline of any employee whose drug test result is confirmed positive as well as follow-up testing; post-accident testing after every on-the-job accident or injury resulting in loss of work time; pre-employment drug testing; random and reasonable suspicion testing of existing employees; discharge or discipline employees for refusal to submit to drug testing; and maintain compliance with the drug free program throughout the year.

You also agree The Hartford has the right to inspect your records and/or workplaces to confirm continued compliance with your statements above. If it is found that these practices are not in place, the premium credit granted in accordance with your statements above will be deleted and additional premiums may be due as a result of your failure to continue such practices.

Signature by or on behalf of the Insured: _____

Title: _____ Date _____

Company: CAMUNDA INC

Policy Number: 08 WEC AP8931

Applicable State(s): _____

WORKERS' COMPENSATION COST CONTAINMENT CERTIFICATION DISCLOSURE STATEMENT

Cost Containment Certification is available from the Colorado Workers' Compensation Cost Containment Board. If you obtain certification, your policy will be subject to a premium credit which will be shown separately on your policy.

PLEASE CHECK ONE (1) OF THE FOLLOWING BOXES BASED UPON YOUR BUSINESS ENTITY QUALIFICATION:

☐ I am aware if my business **does qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business has implemented a certified workers' compensation risk management program, my policy is subject to a 5% premium credit if the loss experience has improved since the last renewal date of workers' compensation insurance. This 5% premium credit is in addition to any schedule rating for which i may qualify.

or,

☐ I am aware if my business **does not qualify** for experience and/or schedule rating under my workers' compensation insurance policy and my business entity has implemented a certified workers' compensation risk management program, my policy is subject to the following premium credit:

Premium Dividend	Dividend Criteria
10%	If my business has been loss free for at least the last year immediately preceding the effective date of the premium credit.
8%	If my business had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium credit.
6%	If my business had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
4%	If my business had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium credit.
2%	If my business had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.
0%	If my business had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium credit.

PLEASE SIGN AND RETURN

Insured Signature _____

Policy Number 08 WEC AP8931

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