CHUBB

MEMORANDUM

To: Texas Employers

From: Chubb Group of Insurance Companies

Re: Employers Compensation Procedures; and
Texas Employee Rights and Responsibilities Under the Texas Workers' Compensation System

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Attached you will find copies of Rules pertaining to Texas Employers and the Texas Workers' Compensation system. These are the relevant Rules for Employers with respect to the reporting of injuries to employees subject to the Texas Workers' Compensation Act and Rules.

Rule 120.1: Employer's Record of injuries

Requires Employer to maintain records of injuries for five years.

Rule 120.2: Employer's First Report of injury

Requires Employer's to timely notify their insurance carrier of all injuries involving more than one day's absence from work and/or all claims involving an occupation disease (including repetitive trauma injuries). The notice of injury must be provided to the insurance carrier no later than eight days from the Employer's receipt of notice of the injury.

Requires Employer's to provide the injured employee with a record of the injury report.

Requires Employer's to provide the injured employee with a written description of the Employee Rights and Responsibilities Under the Texas Workers Compensation System (see Exhibit I).

Rule 120.3: Employer's Supplemental Report of Injury

Requires Employer's to timely file the Employer's Supplemental Report of Injury with the insurance carrier for those claims requiring a First Report of injury to be filed.

Enclosure

Should you have any questions regarding the above, please do not hesitate to contact our Workers' Compensation Claims Unit in our Dallas Branch Office at (800) 873-0777 or (214) 754-0777.

Sincerely,

Workers' Compensation Claims Supervisor
Claims Consultant

Encl. 1. Employee Rights and Responsibilities Under the Texas Workers' Compensation System

2. Employer Responsibilities

3. Texas Rules 120.1, 120.2 and 120.3

4. Texas Labor Code 408.063

5. Texas Administrative Code

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the state. These local offices also provide other workers' compensation system services from the Texas Department of Insurance. This is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

Your Rights in the
Texas Workers' Compensation System

1. **You may have the right to receive benefits.**
   You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:
   - You were intoxicated at the time of the injury;
   - You injured yourself on purpose or while trying to injure someone else;
   - You were injured by another person for personal reasons;
   - You were injured by an act of God;
   - Your injury occurred during horseplay; or
   - Your injury occurred while voluntarily participating in an off-work activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit for this medical care.**

3. **You have the right to choose your treating doctor. If you are in a Workers' Compensation Health Care Network, you can choose your doctor from the network's treating doctor list. If you are not in a network, you can choose a doctor from the Approved Doctor List kept by the Division of Workers' Compensation.**
   It is important to follow all the rules in the workers' compensation system. If you don't follow these rules, you may be held responsible for payment of medical bills.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**
   Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432).

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**
   An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of workers' compensation and provide free assistance to injured employees without attorneys. Ombudsmen cannot sign documents for you, make decisions for you or give legal advice. Proceedings about your claim may include benefit review conferences (BRCs) or contested case hearings (CCHs). Proceedings are held at local field offices. At least one ombudsman is located in each local office.

7. **You have the right for your claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

(SEE REVERSE SIDE FOR RESPONSIBILITIES)

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

Your Responsibilities in the
Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.**
   You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work related.

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network ("network").**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the Texas Department of Insurance network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel.
   If you would like to file a complaint about a network, call the Consumer Help Line at 1-800-252-3439.
   Or file a complaint on the Internet at: www.tdi.state.tx.us/consumer/complfrm.html#wc

3. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

4. **You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. You have one year to send the form after you were injured or first knew that your illness might be work related.**
   Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation.
   Call toll-free 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

5. **You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.**

6. **You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:**
   - You stop working because of your injury;
   - You start working; or
   - You are offered a job.

(SEE REVERSE SIDE FOR RIGHTS)

Contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

Contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

DWC PUB. NO. CS06-007A(6-06)
DWC PUB. NO. CS06-007A(6-06)

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores

Como empleado lesionado en Texas, usted tiene derecho a recibir ayuda por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC, por sus siglas en inglés). Esta ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también proporcionan otros servicios del sistema de compensación para trabajadores por parte del Departamento de Seguros de Texas (TDI, por sus siglas en inglés.) TDI, es una agencia estatal que administra el sistema mediante la División de Compensación para Trabajadores.

Comuníquese con OIEC llamando gratis al teléfono 1-866-EZE-OIEC (1-866-393-6432.) Para información adicional, visite la siguiente página de Internet: www.oiec.state.tx.us.

Comuníquese con la División de Compensación para Trabajadores llamando gratis al teléfono 1-800-252-7031. Para información adicional, visite la siguiente página de Internet: www.tdi.state.tx.us/wc/indexwc.html.

Sus derechos dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted puede tener derecho a recibir beneficios.**
   Usted puede recibir beneficios sin importar quien causó su lesión con ciertas excepciones, tales como:
   - Si usted se encontraba intoxicado cuando ocurrió la lesión;
   - Si usted se lesionó intencionalmente o mientras estaba tratando de lastimar a otra persona;
   - Usted fue lastimado por otra persona por razones personales;
   - Usted fue lastimado por un acto de Dios;
   - Su lesión ocurrió cuando estaba jugando en su trabajo; o
   - Su lesión ocurrió mientras participaba voluntariamente en una actividad fuera del trabajo y después de horas laborables.

2. **Usted tiene derecho a recibir cuidado médico por su lesión o enfermedad relacionada con su trabajo. No existe ningún límite de tiempo para recibir este cuidado médico.**

3. **Usted tiene derecho a escoger su médico tratante. Si usted es parte de una red de servicios médicos de compensación para trabajadores, usted puede escoger su médico de la lista de médicos tratantes de la red de servicios médicos. Si usted no pertenece a una red de servicios médicos, usted debe entonces escoger un médico de la Lista Aprobada de Doctores de la División de Compensación para Trabajadores (DWC, por sus siglas en inglés).**
   Es muy importante que siga los reglamentos del Sistema de Compensación para Trabajadores para evitar que usted tenga que pagar cuentas médicas.

4. **Usted tiene derecho a contratar un abogado en cualquier momento para que le ayude con su reclamo.**

5. **Usted tiene derecho a recibir información y ayuda por parte de la Oficina de Asesoría Pública para el Empleado Lesionado sin costo alguno.**
   El personal de OIEC está disponible para contestar sus preguntas y explicarle sus derechos y responsabilidades llamando al teléfono 1-866-EZE-OIEC (1-866-393-6432).

6. **Usted tiene derecho a recibir ayuda gratuita por parte de un ombudsman si usted no cuenta con un abogado que lo represente en caso que se haya fijado un procedimiento de resolución de disputas.**
   Un ombudsman es un empleado de la Oficina de Asesoría Pública para el Empleado Lesionado. Un ombudsman ha sido entrenado en el campo de compensación para trabajadores para proporcionar ayuda gratis a empleados lesionados que no cuentan con un abogado. Un ombudsman no puede firmar documentos por usted, hacer decisiones por usted o dar opinión o asesoramiento legal. Los procedimientos en relación a su reclamo pueden incluir Conferencias para Revisión de Beneficios (BRC, por sus siglas en inglés) o Audiencias para Disputar Beneficios (CCH, por sus siglas en inglés). Los procedimientos se llevan a cabo en las oficinas locales de la División. En cada oficina local hay por lo menos un ombudsman.

7. **Usted tiene derecho a que la información sobre su reclamo se mantenga confidencial.**
   En la mayoría de los casos, el contenido de un expediente de reclamo no puede ser obtenido por otros. Las únicas personas que necesitan saber acerca de su reclamo son su empleador y la compañía de seguros de su empleador. También, un posible o futuro empleador puede recibir información limitada acerca de su reclamo por parte de la División de Compensación para Trabajadores.

(Ver al reverso para sus responsabilidades)

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores

Sus responsabilidades en el Sistema de Compensación para Trabajadores

1. **Usted tiene la responsabilidad de informarle a su empleador si usted se ha lesionado en el curso y amplitud de su empleo.**
   Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o del día en que usted supo que la lesión o enfermedad estaba relacionada con su trabajo.

2. **Usted tiene la responsabilidad de saber si usted pertenece a una red de servicios médicos de compensación para trabajadores.**
   Si usted no sabe si pertenece a una red de servicios médicos, pregúntele al empleador para el cual usted trabajaba cuando se lesionó. Si usted es parte de una red de servicios médicos, usted tiene la responsabilidad de seguir los reglamentos de dicha red. Su empleador debe darle una copia de los reglamentos de la red de servicios médicos del Departamento de Seguros de Texas. Lea los reglamentos cuidadosamente. Si usted encuentra algo que no entiende, pregunte a su empleador o llame a la Oficina de Asesoría Pública para el Empleado Lesionado. Si usted desea someter una queja referente a la red de servicios médicos, llame a la Línea de Asistencia al Consumidor al teléfono 1-800-252-3439. Para someter su queja en línea, visite la siguiente página de Internet: www.tdi.state.tx.us/consumer/complfrm.html#wc.

3. **Usted tiene la responsabilidad de informarle a su médico como se lesionó y si usted cree que la lesión está relacionada con el trabajo.**

4. **Usted tiene la responsabilidad de completar y enviar el formulario de reclamo DWC-41 a la División de Compensación para Trabajadores. Este formulario debe ser enviado dentro de un año a partir de la fecha en que usted se lesionó o a partir de la fecha en que usted supo que su enfermedad estaba relacionada con su trabajo.**
   Envíe el formulario DWC-41 completo, aún cuando usted ya esté recibiendo beneficios. Si usted no envía el formulario completo a la División de Compensación para Trabajadores dentro del tiempo señalado, usted puede perder sus derechos para recibir beneficios. Para recibir una copia del formulario DWC-41, llame al teléfono 1-800-252-7031.

5. **Usted tiene la responsabilidad de proporcionar su dirección actual, número de teléfono e información sobre su empleador a la División de Compensación para Trabajadores y la compañía de seguros.**

6. **Usted tiene la responsabilidad de informarle a la División de Compensación para Trabajadores y a la compañía de seguros cada vez que exista un cambio en el estado de su empleo o su salario. Por ejemplo:**
   - **Si usted deja de trabajar por causa de su lesión;**
   - **Usted regresa a trabajar; o**
   - **Usted recibe una oferta de trabajo.**

(Ver al reverso para sus derechos)

Comuníquese con OIEC llamando gratis al teléfono 1-866-EZE-OIEC (1-866-393-6432.) Para información adicional, visite la siguiente página de Internet: www.oiec.state.tx.us.

Comuníquese con la División de Compensación para Trabajadores llamando gratis al teléfono 1-800-252-7031. Para información adicional, visite la siguiente página de Internet: www.tdi.state.tx.us/wc/indexwc.html.

DWC PUB. NO. CS06-007A(6-06)
DWC PUB. NO. CS06-007A(6-06)

Employer Responsibilities

Information for Employers from the Division of Workers' Compensation

What is Workers' Compensation Insurance Coverage?

Texas employers, except for public entities, can choose whether or not to provide workers' compensation insurance coverage for their employees. Workers' compensation provides covered employees with income and medical benefits if they are injured on the job or have a work-related injury or illness. Workers' compensation is regulated by the Texas Department of Insurance, Division of Workers' Compensation (the Division).

Participation in the workers' compensation system in Texas is voluntary for most employers. Employers who choose to have workers' compensation insurance may:

- purchase a workers' compensation insurance policy from a private insurance company;
- self-insure, if the employer can meet the requirements to self-insure under the Texas Workers' Compensation Act (the Act) and is certified through the Division;
- self-insure through the Texas Department of Insurance with a group of same or similar private employers; or
- if a governmental entity, purchase a workers' compensation policy from a private insurance company, or self-insure either individually or as a group.

With few exceptions, workers' compensation insurance limits the employer's liability for the work-related injury or death sustained by the employee.

For additional information, visit the Division's website for:

- Information regarding benefits that employees are eligible for: www.tdi.state.tx.us/wc/information/benefits.html.
- Information regarding Employer Rights and Responsibilities: www.tdi.state.tx.us/wc/employer/employers.html.
- Information about how to become self-insured through the Division: www.tdi.state.tx.us/wc/si/selfins.html.

This publication is a summary and is presented for informational purposes only. It is not a substitute for the statute and Division rules. For questions about Division rules, please call Customer Assistance at 1-800-252-7031. CS05-017D(8-07)

COVERED EMPLOYERS

Employer Responsibilities

An employer must report the following to its insurance carrier within eight (8) days of the date:

- an employee misses more than one (1) day of work because of a work-related injury;
- an employer knows about an occupational disease or illness even if the employee has not missed any work; or
- an employee dies because of a work-related injury, or illness.

An employer may report the injury or illness to its insurance carrier by mail, fax, telephone, or electronic transmission and should keep a record of the date each injury is reported to its carrier.

An employer is required to provide a copy of the completed *Employer's First Report of Injury or Illness*, (DWC Form-1) to the injured employee at the same time the injury is reported to its insurance carrier. An employer must also provide a copy of "*Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System*" to the injured employee.

To view or print a copy of the *Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System*, visit the Division's website at www.tdi.state.tx.us/wc/employee/workerrights.html.

The insurance carrier and the employer may agree to have the insurance carrier send a copy of the *Employer's First Report of Injury and Illness* (DWC Form-1) and *Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System* to the injured employee. However, an employer can be fined up to $500 per occurrence if the employer or the carrier fails to provide this information.

For further assistance, call
1-800-252-7031
or visit
www.tdi.state.tx.us

Employer Responsibilities

Information for Employers from the Division of Workers' Compensation

Employer's Wage Statement
[Rule 120.4]

An employer is required to report an injured employee's wages and other fringe benefits (i.e. health premiums, uniform allowance, etc.) to the insurance carrier. The employer is required to send the *Employer's Wage Statement* (DWC Form-3) to the insurance carrier and the injured employee within 30 days of the date that income benefits begin to accrue (the 8th day missed from work). An employer is not required to send a copy of the wage statement to the Division unless the Division requests the statement.

Supplemental Report of Injury
[Rule 120.3]

An employer must report any changes in an injured employee's pay or employment status to the insurance carrier. The employer must send the *Supplemental Report of Injury* (DWC Form-6), to the insurance carrier and the injured employee within:

- ten (10) days from the end of a pay period in which an injured employee's pay changes; and
- ten (10) days from the date an injured employee resigns or is terminated; and
- three (3) days from the date an injured employee returns to work; and
- three (3) days from the date an injury causes an employee to miss additional work after returning to work.

If an employer does not send the required forms, or does not send the forms on time, the employer could be fined up to $500 per occurrence.

Record-Keeping Responsibilities
[Section 409.006, Rule 120.1]

An employer must keep a record of all work-related injuries, illnesses, and fatalities. The records must be kept for at least five (5) years from the last day of the year in which the injury, illness or fatality occurred, or for the period of time required by the Occupational Safety and Health Administration (OSHA), whichever is longer.

If these records are not kept, an employer could be fined up to $500 per occurrence.

Notice Responsibilities
[Sections 409.043, 406.007, 406.034, Rules 110.101, 110.108]

Written notice must be posted in the workplace in English and Spanish and any other language that is appropriate telling employees that:

- the employer has workers' compensation insurance, and the workers' compensation insurance company's name;
- information regarding the Division's Ombudsman program; and
- the Division's toll-free telephone number to report unsafe work conditions.

The notice must be placed in the employer's personnel office (if any) and in a prominent place where employees can see it regularly. The notice must be in the wording and format adopted by the Division (Notice-6). To obtain Notice-6, visit the Division's website at www.tdi.state.tx.us/forms/form20all.html.

If the notice is not posted, the employer could be fined up to $1,000.

Notice to New Employees
[Section 406.034, Rule 110.101]

An employer is required to give written notice of coverage to new employees upon hire and inform them of their right to reject workers' compensation coverage and retain their common law right of action. If at any time the coverage terminates and then the employer again obtains new coverage, the employer is required to give all employees this information in writing. To review the rule and obtain the required wording for this notice, visit the Division's website at www.tdi.state.tx.us/wc/rules/110.pdf.

The Division encourages an employer to keep a copy of the notice provided to each new employee. The notice may be signed and dated by the employer and the new employee.

If this notice is not provided to new employees, the employer could be fined up to $500 per occurrence.

Notice of Change in Coverage
[Section 406.005, Rule 110.1]

An employer must give all employees written notice if the employer requests cancellation of the workers' compensation policy or if the insurance carrier cancels the policy. The notice must be given to all employees within 15 days from the date the request for cancellation was made or the date the employer receives notice from the insurance carrier that the carrier intends to cancel the policy.

If this notice is not provided to all employees, the employer could be fined up to $500 per occurrence.

For more information on workers' compensation for employers see the following facts sheets:

- Employers Rights
- Non-Covered Employers

Employer Rights

Information for Employers from the Division of Workers' Compensation

What is Workers' Compensation Insurance Coverage?

Texas employers, except for public entities, can choose whether or not to provide workers' compensation insurance coverage for their employees. Workers' compensation provides covered employees with income and medical benefits if they are injured on the job or have a work-related injury or illness. Workers' compensation is regulated by the Texas Department of Insurance; Division of Workers' Compensation (the Division).

Participation in the workers' compensation system in Texas is voluntary for most employers. Employers who choose to have workers' compensation insurance may:

- purchase a workers' compensation insurance policy from a private insurance company;
- self-insure, if the employer can meet the requirements to self-insure under the Texas Workers' Compensation Act (the Act) and is certified through the Division;
- self -insure through the Texas Department of Insurance with a group of same or similar private employers; or.
- if a governmental entity, purchase a workers' compensation policy from a private insurance company, or self-insure either individually or as a group

With few exceptions, workers' compensation insurance limits the employer's liability for the work-related injury or death sustained by the employee.

For additional information, visit the Division's website for:

- Information regarding benefits that employees are eligible for www.tdi.state.tx.us/wc/information/benefits.html.
- Information regarding Employer Rights and Responsibilities www.tdi.state.tx.us/wc/information/employers.html.
- Information about how to become self-insured through the Division www.tdi.state.tx.us/wc/dwc/division/selfins.html.

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Covered Employer Rights

The Texas Workers' Compensation Act provides a covered employer the following rights:

- the right to contest the compensability of a workers' compensation claim (claim) if the employer's insurance carrier accepts liability. Contesting the compensability of a claim means the employer can present evidence in dispute resolution proceedings held at the Division and in court that indicates the employee's injury, illness, or death did not occur on the job or is not work-related.
- the right to receive notice, after making a written request to the insurance carrier, about any dispute resolution proceeding or court proceeding related to an employee's claim, or any proposal to settle the claim by an agreement.
- the right to attend all dispute resolution proceedings related to an employee's claim.
- the right to present relevant evidence about disputed issues at dispute resolution proceedings.
- the right to report suspected workers' compensation fraud to the Division or to the insurance carrier.
- the right to contest the failure of the insurance carrier to provide accident prevention services required by the Act.

For additional information regarding dispute resolution and a list of the Division's local offices in your area, visit the Division's website at www.tdi.state.tx.us/wc/information/dispute.html or http://www.tdi.state.tx.us/wc/dwccontacts.html#offices.

To obtain the forms to dispute a claim (DWC Form-4 and DWC Form-45), visit the Division's website at www.tdi.state.tx.us/wc/forms/index.html.

For further assistance, call
1-800-252-7031
or visit
www.tdi.state.tx.us

Reimbursement of Voluntary Payments Made by an Employer
[Section 408.003, Rules 126.13, 129.7]

Whether an employer may be reimbursed for voluntary payment of benefits paid to an injured employee depends on the type of payments made and when the payments were issued.

An employer is eligible for reimbursement of voluntary payment of benefits the employer has paid to an injured employee when:

- the carrier has denied liability for the injury, the employer does not agree, and the injury is determined compensable; or
- the carrier has not completed its initial investigation. **(Please Note: an employer is only allowed to pay benefits in this situation for the first two weeks after the injury).**

In the situations above, the employer must file the *Employer's Report for Reimbursement of Voluntary Payment* (DWC Form-2) detailing the total amount of voluntary payments made up to the point when the carrier notified the employer that they have accepted liability for the injury and have begun benefit payments. The carrier must reimburse the employer for the amount of benefits the carrier would have paid. If the employer made payments in excess of what the carrier would have paid in benefits, the excess amount is not reimbursable unless there is a written agreement between the injured employee and the employer that the excess amount can be recouped from future impairment income benefits paid by the carrier, if any.

An employer is not eligible for reimbursement of wages paid to continue the employee's full salary after an injury if the carrier has initiated benefits. An employer must ensure the carrier is aware the employer is paying full salary to the employee to prevent the carrier from paying Temporary Income Benefits (lost wage benefits) for the same time period. An employer who pays salary to supplement the difference between the 70 percent or 75 percent of the employee's average weekly wage that is being paid by the carrier is not entitled to and may not seek reimbursement from the employee or the carrier.

For more information on workers' compensation for employers see the following fact sheets:

- Employer Responsibilities
- Non-Covered Employers

CHAPTER 120. COMPENSATION PROCEDURES - EMPLOYERS

§120.1. Employer's Record of Injuries.

(a) An employer shall keep a record of all injuries and fatal injuries to employees as reported to an employer, or otherwise made known to an employer. The record shall include:

(1) the name, address, date of birth, sex, wage, length of service, social security number, and occupation of the employee;

(2) the reported cause and nature of the injury, the part of the body affected, and a description of any equipment involved;

(3) the date, time, and location where the injury occurred;

(4) the name of the employee's immediate supervisor;

(5) the names of any witnesses (if known);

(6) the name and address of the treating health care provider, if known; and

(7) any voluntary benefits paid by the employer under the Texas Workers' Compensation Act (Act), §4.06.

(b) These records shall be open to inspection by the commission, upon at least five working days notice to the employer, at a reasonable time and place.

(c) The employer shall retain a record of an injury until the expiration of five years from the last day of the year in which the injury occurred or the period of time required by Occupational Safety and Health Administration standards and regulations, whichever is greater.

(d) An employer who does not maintain a record, or who refuses to make the record available to the commission, may be assessed an administrative penalty not to exceed $500.

The provisions of this §120.1 adopted to be effective January 11, 1991, 16 TexReg 115.

§120.2. Employer's First Report of Injury.

(a) The employer shall report to the employer's insurance carrier each death, each occupational disease of which the employer has received notice of injury or has knowledge, and each injury that results in more than one day's absence from work for the injured employee. As used in this section, "knowledge" means receipt of written or verbal information regarding diagnosis of an occupational disease, or the diagnosis of an occupational disease through direct examination or testing by a doctor employed by the employer.

(b) The report shall contain the information required by §120.1(a) of this title (relating to Employer's Record of Injuries), any additional information prescribed by the commission in accordance with the Texas Labor Code, §402.042(b)(11), and shall contain the information necessary for an insurance carrier to electronically transmit a first report of injury to the commission. The commission shall prescribe the form, format, and manner of the report.

(c) The report shall be filed not later than the eighth day after the receipt of notice of injury or the acquisition of knowledge of an occupational disease, or the eighth day after the employee's absence for more than one day from work due to injury or death. For purposes of this section, a report is filed when personally

delivered, mailed, reported via tele-claims, electronically submitted or sent via facsimile. The employer shall maintain a record of the date the report of injury is filed with the insurance carrier.

(d) The employer shall provide a written copy of the report to the injured employee or to the employee's last known mailing address, at the time the report is filed with the insurance carrier. The written report may be the report specified in subsection (b) of this section or at a minimum shall contain the information listed in §120.1(a) of this title (relating to Employer's Record of Injuries).

(e) The employer shall also provide the employee a summary of rights and responsibilities at the time the report required in subsection (c) of this section is filed with the insurance carrier. The text for the summary shall be in English and Spanish, or in English and any other language common to the employee. This does not preclude the employer or carrier from providing the employee with additional information but such information must be separate from and in addition to the text contained in this subsection and may not infer that the additional information is being provided or required by the Commission. The following English text and the Spanish text provided by the commission must be used without any additional words or changes.

YOUR RIGHTS IN THE TEXAS WORKERS' COMPENSATION SYSTEM

1. ***You may have the right to receive benefits.***
   You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefits if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured by another person for personal reasons, you were injured while voluntarily participating in an off-work activity, you were injured by an act of God, or your injury occurred during horseplay.

2. ***You have the right to receive the medical care reasonable and necessary to treat your work-related injury or illness for the rest of your life.***

3. ***You have the right to the initial choice of doctor.***
   You may not change doctors except with the approval of the Commission. You do not need to get approval to go to a different doctor for emergency treatment, if you or your doctor moves or if your doctor is unable to continue treating you.

4. ***You have the right to hire an attorney to help you get benefits or to help you resolve disputes.***

5. ***You have the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding, from a Commission ombudsman free of charge. To request assistance, contact the field office handling your claim, or call 1-800-252-7031.***
   You have the right to receive information and assistance regarding your claim. Commission staff will explain your rights and responsibilities under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Commission ombudsman in informal dispute resolutions and in administrative proceedings if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you.

6. ***You have the right to confidentiality.***
   Only people who need to know - such as your doctor, your employer or your employer's insurance carrier - may see information in the commission's files. A prospective employer may get limited information from the commission about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for them to do so.

YOUR RESPONSIBILITIES UNDER THE TEXAS WORKERS' COMPENSATION SYSTEM

1. ***You have the responsibility to tell your employer about your injury or illness.***
   You must tell your employer ***within 30 days*** of the date you were injured, or ***within 30 days*** of the date you first knew your illness might be work-related. You, or someone helping you, may either talk with or write your employer or any supervisor where you work.
   If you do not tell your employer within 30 days, you could lose your right to get benefits.

2. ***You have the responsibility to fill out a claim form and send it to the Commission.***
   You must send a completed claim form, called a TWCC-41, to the Commission ***within one year*** of the date you were injured, or ***within one year*** of the date you first knew your illness might be work-related.
   Send the completed claim form to the Commission even if you are already getting benefits.
   If you do not send the form within one year, you could lose your right to get benefits. For a copy of the form, call the field office handling your claim, or call 1-800-252-7031.

3. ***You have the responsibility to tell the Commission and the insurance carrier any time your income changes.***
   If you are NOT getting benefits and you have changed employers since your injury, tell the Commission if your injury causes you to miss work or lose income. Call 1-800-252-7031.
   If you ARE getting benefits and you have changed employers since your injury, tell the commission and the insurance carrier paying your benefits if your income changes. Tell the commission and the insurance carrier regardless of whether your income went up or down.
   If you have stopped working since your injury, tell the commission and the insurance carrier if you start working again or if you have a job offer.

4. ***You have the responsibility to tell your doctor how you were injured and if you believe it may be work-related.***
   If possible, tell the doctor before the doctor treats you.

5. ***You have the responsibility to tell the commission and the insurance carrier how to contact you.***
   You should contact the commission and the insurance carrier if your home address, work address, or phone number change, so the commission and the insurance carrier will be able to contact you when necessary.

(f) The employer shall maintain a record of the date the copy of the report of injury and the summary of rights and responsibilities were provided to the employee.

(g) If a report has not been received by the insurance carrier, the employer has the burden of proving that the report was filed within the required time frame. If the carrier receives the report by mail, it will be presumed that the report was mailed four days prior to the date received by the carrier. The employer has the burden of proving that good cause exists if the employer failed to timely file or provide the report.

(h) Failure of an employer to file the report as required with the insurance carrier or to provide a copy of the report as required to the employee without good cause is subject to a penalty not to exceed $500, pursuant to Texas Labor Code, §409.005, and may be subject to a penalty not to exceed $10,000 pursuant to Texas Labor Code, §415.021, for repeated violation. An employer who fails to file the report as required by this rule and by the Texas Labor Code, §409.005, waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

The provisions of this §120.2 adopted to be effective January 11, 1991, 16 TexReg 115; amended to be effective January 1, 1993, 17 TexReg 8295; amended to be effective December 4, 1995, 20 TexReg 9698.

§120.3. Employer's Supplemental Report of Injury.

(a) As used in this section, the term "employer" means the employer for whom the injured employee (employee) was working when injured and the filing requirements apply during the time the employee is entitled to temporary income benefits. The employer's duty to file reports required by this section continues until the employee reaches maximum medical improvement (MMI) or is no longer employed by the employer and the employer has made the report required by subsection (b) of this section. The employer may contact the insurance carrier (carrier) for information regarding the employee's MMI status.

(b) As provided in §129.4 of this title (relating to Adjustment of Temporary Income Benefit Amount), the employer shall file the Supplemental Report of Injury, in the form, format and manner prescribed by the Commission. The report shall be filed with the employer's carrier and provided to the employee within ten days after the end of each pay period in which the employee has a change in earnings as a result of the injury or within ten days after the employee resigns or is terminated. The requirement to report a change of earnings under this subsection includes reporting all post-injury earnings as that term is used in Chapter 129 of this title (relating to Temporary Income Benefits).

(c) For injuries requiring an Employer's First Report of Injury, unless the information required in this subsection is provided on the Employer's First Report of Injury, the employer shall file the Supplemental Report of Injury with the employer's carrier and provide a copy to the employee within three days after:

(1) the employee begins to lose time from work as a result of the injury;

(2) the employee returns to work; or

(3) the employee, after returning to work, experiences an additional day(s) of disability as a result of the injury.

(d) The employer shall file the supplemental report of injury with the carrier by personal delivery, telephone, facsimile or electronic transmission. The employer shall provide a copy of the report to the employee by facsimile or electronic transmission if the employee has identified a personal facsimile number or a personal email address to be used and the employer has the means of sending such a transmission. Otherwise the report shall be provided by personal delivery or sent by mail.

(e) The employer shall maintain a record of the date the Supplemental Report of Injury is filed with the carrier and provided to the employee. If a report required by this section has not been received by the required recipient, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause exists if the employer failed to file the report.

The provisions of this §120.3 adopted to be effective January 1, 1993, 17 TexReg 8296; amended to be effective December 4, 1995, 20 TexReg 9698; amended to be effective December 26, 1999, 24 TexReg 11394.

§120.4 Employer's Wage Statement.

(a) The employer is required to timely file a complete wage statement in the form and manner prescribed by the commission. As used in this section, the term "filed" means "received."

(1) The wage statement shall be filed with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the date the employer is notified that the employee is entitled to income benefits;

(B) the date of the employee's death as a result of a compensable injury.

(2) A subsequent wage statement shall be filed with the carrier, claimant, and the claimant's representative (if any) within seven days of a change in any wage information provided on the previous wage statement (such as because the employer has discontinued providing a nonpecuniary wage that was originally continued after the injury).

(3) The wage statement shall be filed with the commission within seven days of receiving a request from the commission.

(b) The employer shall ensure timely delivery of the written wage statement, however, if agreed upon by the employer and the carrier, the wage statement filed with the carrier may be filed orally. The carrier may also agree to provide the wage statement to the claimant and the claimant's representative, if any. However, the employer remains responsible for ensuring timely delivery of the wage statement and the employer has the burden of proving that the wage statement was timely filed. Therefore, employers should file the wage statement by verifiable means and maintain a record of the:

(1) information provided;

(2) date filed; and

(3) means of filing with each recipient required to receive the report.

(c) The wage statement shall include:

(1) the employee's name, address, and social security number;

(2) the date of the employer's hire of the employee;

(3) the date of injury;

(4) the employer's name, address, and federal tax identification number;

(5) an identification of the employment status (e.g. if the employee works full-time, part-time, etc.);

(6) the name of the person submitting the report;

(7) the wage information required by subsection (d) of this section; and

(8) a certification that the wage information provided includes all wage information required by subsection (d) of this section and that the information is complete and accurate.

(d) The employer shall provide wage information in accordance with this subsection.

(1) Employers other than school districts shall report the employee's wage, as defined in §128.1 of this title (relating to Average Weekly Wage: General Provisions), earned by the employee during the 13 weeks immediately preceding the date of injury and the number of hours the employee worked to earn the wages being reported.

(2) School district employers shall report the wages that would be deducted from the employee's salary if the employee were absent from work for one week and did not have personal leave available to compensate for the wages lost that week.

(A) For employees employed through a written contract, the employer shall report the full value of the contract that would be paid (including any stipend the employee was earning or scheduled to receive) if the employee were to fully complete the terms of the contract and:

(i) the number of days that the employee was required to work under that contract; or

(ii) the number of months that the employee was required to work under that contract (whichever is applicable).

(B) For employees who are NOT employed through a written contract, the employer shall report the pecuniary wages earned by the employee during the 13 weeks immediately preceding the date of injury and the number of hours the employee worked to earn the wages being reported.

(C) For all employees, the employer shall report the pecuniary wages earned by the employee in the 12 months immediately preceding the injury.

(3) This subsection applies if the employer is required to report 13 weeks of wage information under subsection (d)(1) or (d)(2)(B) of this section (i.e. it does not apply if the employee was an employee of a school district employed through a written contract).

(A) If the employee is paid on a monthly or a semi-monthly basis, the employer may provide the wages earned in the three months immediately preceding the injury; if the employee is paid on a biweekly basis, the employer may provide the wages earned in the 14 weeks immediately preceding the injury; otherwise the employer shall provide the wages earned in the 13 weeks immediately preceding the injury.

(B) If the employee was not employed for 13 continuous weeks before the date of injury and the employee was not employed by a school district through a written contract:

(i) the employer shall identify a similar employee performing similar services, as those terms are defined in §128.3 of this title (relating to Average Weekly Wage Calculation For Full-Time Employees, and For Temporary Income Benefits For All Employees), and list the wages of that similar employee; however if

(ii) the employer does not have a similar employee who has been employed for 13 continuous weeks prior to the injured employee's date of injury, the employer shall provide the wages earned by the employee during the period the employee was employed.

The provisions of this §120.4 adopted to be effective May 16, 2002, 27 TexReg 4027.

Texas Administrative Code

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 128	BENEFITS--CALCULATION OF AVERAGE WEEKLY WAGE
RULE §128.2	**Carrier Presumption of Employee's Average Weekly Wage**

(a) An insurance carrier (carrier) shall promptly initiate the payment of income benefits as required by the Workers' Compensation Act (Act). To expedite payment, the carrier shall presume that multiplying the employee's hourly rate times the average number of hours in the employee's standard work week, or, if such information is not available, that the employer's last payment to the employee for personal services based on a full week's work (a partial work week shall be prorated for a full week) accurately reflects the employee's average weekly wage (AWW) until:

(1) the employer files a complete wage statement required by §120.4 of this title (relating to Employer's Wage Statement); or

(2) the correct AWW is determined by other evidence (such as that described in subsections (b) and (c) of this section), if the employer does not file a complete wage statement or if the employee files an Employee's Multiple Employment Wage Statement in accordance with §122.5 of this title (relating to Employee's Multiple Employment Wage Statement).

(b) In the absence of a properly completed wage statement, the carrier shall calculate the correct wage by using available wage information in a manner which is fair, just, and reasonable, and which involves a methodology that allows the closest approximation of a calculation based upon a 13 week average as required by this chapter (for example, pecuniary wages would be included regardless of whether the employer continues them and earnings after the date of injury would not be included). Subsection (c) of this section provides examples of how to do this.

(c) This subsection provides a non-inclusive list of methods that carriers can use to calculate the correct AWW using evidence other than a complete wage statement. There may be other, similar but unlisted methods that are also appropriate in a given situation.

(1) For a salaried employee, paid on monthly or semi-monthly basis, whose salary has not changed in the 13 weeks prior to the compensable injury, the carrier may presume that the AWW is equal to 3 months of wages divided by 13.

(2) For an employee on whom the carrier receives 14 weeks of wage information but is unable to identify the amount of the wages paid in the 14th week (thus leaving 13 usable weeks), the carrier may presume that the AWW is equal to the 14 weeks of wages divided by 14.

(3) For an employee on whom the carrier receives less than 13 weeks of wage information because the employee was not employed with the employer for 13 weeks prior to the injury, the carrier may presume that the AWW is equal to the amount of wages paid divided by the number of weeks for which the wages were earned.

(d) Upon receipt of a properly completed wage statement the carrier shall recalculate the AWW in accordance with the applicable rule(s).

(e) If, at the time that income or death benefits first accrue, the carrier has not received a complete wage statement as required by §120.4 of this title (relating to Employer's Wage

Statement), the carrier shall notify the employer that the wage statement is now required under the Statute and Rules.
(f) If a carrier receives a wage statement that indicates that the employee was provided nonpecuniary wages prior to the date of injury but that does not indicate whether the employer is going to continue them or not, the carrier shall assume that the nonpecuniary wages are not being continued by the employer until and unless the carrier is able to verify that the nonpecuniary wages are being continued by the employer.
(g) In the event that the claimant or the carrier believes that the AWW computed by following the calculations in this rule does not reflect the true AWW, the claimant and carrier may enter into a written agreement on the AWW or request a benefit review conference.

Source Note: The provisions of this §128.2 adopted to be effective January 11, 1991, 15 TexReg 118; amended to be effective September 1, 1993, 18 TexReg 5213; amended to be effective May 16, 2002, 27 TexReg 4036

§ 408.063. WAGE PRESUMPTIONS; ADMINISTRATIVE VIOLATION.

(a) To expedite the payment of income benefits, the commissioner may by rule establish reasonable presumptions relating to the wages earned by an employee, including the presumption that an employee's last paycheck accurately reflects the employee's usual wage.

(b) Not later than the 30th day after the date the employer receives notice of an injury to the employee, the employer shall file a wage statement showing the amount of all wages paid to the employee.

(c) An employer who fails to file a wage statement in accordance with Subsection (b) commits an administrative violation.

Acts 1993, 73rd Leg., ch. 269, § 1, eff. Sept. 1, 1993. Amended by Acts 2005, 79th Leg., ch. 265, § 3.103, eff. Sept. 1, 2005.

Workers Compensation

Texas Policyholders Loss Prevention and Your Business

Chubb policyholders can begin the process of preventing accidents and controlling potential exposures using this kit from Chubb's loss control professionals. This guide provides basic information to help establish a functional loss control program in your business. Working in partnership with your governing agencies, Chubb loss control emphasizes safety and loss prevention. The guide blends Chubb Loss Control know how with excerpts from:

- ***Texas Workers Compensation Commission Accident Prevention Plan Program Guide for Small Business Employers*** Pub No. HS96-103 (01/02)
- ***and OSHA 2254 Training Requirements in OSHA Standards and Training Guidelines, 1998.***

No matter how many employees you have, no matter how large or small your business is, the suggestions and information in this guide can help you control the cost associated with workplace accidents. This guide is not meant to be a complete program, only as a supplement to your existing loss control program.

Introduction

There's no way around it. Accidental loss of life, health or property in your business takes money right out of your bottom line. Installing a sprinkler system, properly handling hazardous chemicals, replacing a ladder before a worker is seriously injured – these actions help you to preserve life, property and profit.

The potential for loss can be obvious or hidden. Improper eye protection, for example, can lead to eye injuries on the job. The results? Human suffering and reduced productivity. But even less obvious problems like inadequate ventilation can lead to high rates of employee absenteeism and lost production.

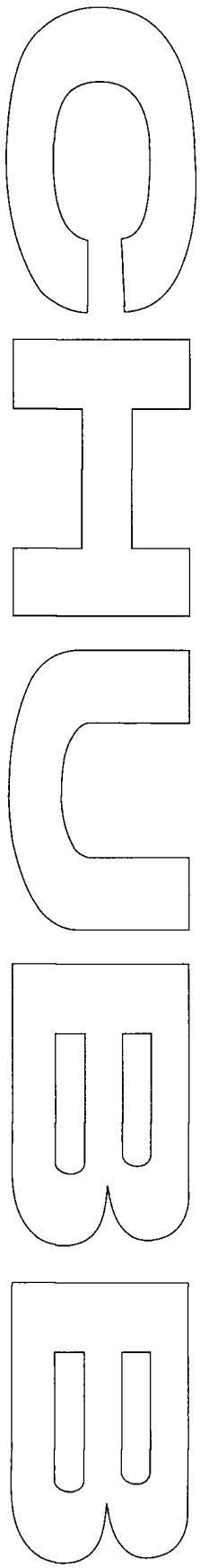
What can you do? Losses are hard to predict. But one thing is certain. Unsafe acts and conditions cause accidents. Identify the causes of accidents and you can take corrective steps to minimize loss.

In the long term, you will see a difference in your bottom line.

Why?

A strong loss control program provides many benefits. One of these benefits is protecting the assets of your business. Many businesses define the assets as buildings, stock and equipment. Careful examination of your business would show a hidden asset, your employees. A well-run loss control program will reduce the potential injury to your employees, allowing them to work productively, positively impacting your bottom line. In addition, when employee injuries occur, the accident may involve additional costs such as damage to stock, equipment or property.

A careful analysis of your workplace accidents can be a real eye opener. Many businesses will focus on the direct cost to the business that is readily documented in insurance loss runs such as, payments to doctors or lost time payments to employees. There is an additional cost that may be buried in the overhead of the business but is attributable to employee accidents. This figure is sometimes referred to as the "indirect cost" of accidents and statistics have shown that this amount is usually five times the level of the direct cost. In most cases, insurance companies pay the entire direct cost, while the indirect cost comes directly from the business bottom line.



These indirect costs can include: overtime for employees needed to replace the injured worker and damage to equipment or products as a result of an accident. Some of the other costs would be the salary cost of the supervisor spent investigating accidents, the salary cost of administrative personnel for time spent following up on claim payment and the potential fines or penalties that may be levied by state or federal agencies as a result of the accident.

Workers Compensation

Employers are required to provide workers compensation insurance for employees. There is a direct relationship between a strong loss control program and lower workers compensation costs. In 2001 over 136,246,000 employees were covered by workers' compensation. In the same year there were 3,900,000 disabling injuries and 5,300 fatalities. The total cost to American business was $132.1 billion and 85,000,000 lost workdays. The most effective method of controlling your cost of workers compensation is with an effective loss control program.

The Cost to Your Business

The average American business pays almost 5.5 % of its pre tax corporate profits for workers' compensation insurance. In terms of payroll, 2.3 cents of every payroll dollar is for workers compensation insurance. This expense can be controlled by incorporating pre and post injury management practices.

What is Workers' Compensation?

It is a "no fault" system. In order to collect medical or loss of wage benefits, the injured worker does not have to prove negligence. The injury must arise out of or in the course of employment. Each state has its own laws governing workers' compensation. Employers in all states are required to carry workers' compensation or to be self-insured.

What's Paid?

The injured worker is compensated for work related injuries including medical bills and lost wages. The amount to be paid for medical treatment is usually governed by state law. State law also governs the amount paid for lost wages and the maximum amount paid is generally 60% to 70% of the average wage in a particular state.

Your Experience Counts

Most companies that pay more than $3,000 in WC premiums are experience rated. The loss experience of your company is compared to similar businesses in your state. For example, if you are a machine shop, you are compared to all other machine shops in the state. If your business has average losses, you are given an experience modification of 1.00.

If the experience modification is poorer than average this is a debit mod (above 1.00). If the experience modification is better than average this is a credit mod (below 1.00).

For example, a mod of 1.75 means the company is paying 75 % higher workers' compensation rates than the average business in a particular industry. On the other hand, a credit mod of .5 means the rates are half the industry average.

The National Council on Compensation Insurance (NCCI) www.ncci.com provides more information on experience modifications.

What Determines the Mod?

Although the rules vary from state to state, the following is generally true. The experience modification is a three-year rolling average. The frequency or number of claims has a greater impact than severity or dollars paid. Claims impact the experience modification only if the insurance company pays out money. These claims are required to be reported to the state rating bureau by your insurance carrier.

Basic Elements of Loss Control Plan

Not all hazards at your worksite depend on an accident to cause harm. Worker exposure to toxic chemicals or harmful levels of noise or radiation may occur in conjunction with routine work as well as by accident. The effect may not appear immediately, but it may be harmful in the long run. You need a plan that includes prevention in the "health hazard exposures" as well as accidents. You need a loss control program.

It is not a difficult task to develop such a plan. Basically, you only need to concern yourself with those types of accidents and health hazard exposures that could in your workplace. Because each workplace is different, your program may be different from your neighbor or competitor. You want a plan that works for your business and work environment.

Federal and state occupational safety and health regulations apply for most businesses. Employers who do not adhere to the regulations are subject to fines and adverse publicity.

A good loss control program should contain the following seven elements:

Management

Experience has shown that sincere commitment and active participation by management are necessary if a loss control program is to achieve beneficial results. When management demonstrates genuine interest in preventing accidents and providing a safe workplace, supervisors and employees are more likely to do the same.

A loss control program is more likely to accomplish the desired results when safety goals have been clearly established. Goals should give a clear understanding of what you expect, should be realistic and should be easy. For example, if your operation has a high accident experience, a realistic and quantitative goal may be to reduce accident frequency by 25% during the next year. Safety goals should be established for every organization, regardless of size.

Management should demonstrate active participation by translating ideas into specific safety actions such as:

- Issuing a written statement of a safety policy.
- Providing realistic allocations of time and money for safety items.
- Assigning responsibility and authority for implementing and enforcing your loss control program.
- Reacting promptly to recommendations, suggestions, complaints, etc. developed as a result of the loss control program.
- Attending safety talks and meetings.
- Demonstrating safe behavior and concern for the safety of others.

Written Safety Policy

You should prepare a safety policy statement to develop employee awareness and involvement. You must set a good example and communicate your intent to all employees. To do this, write a short statement of safety policy; sign it, and place it in a visible location for all to see and refer to. A sample safety policy could be:

"It is the intent of this company to provide a safe place for you to work. Accident and injury prevention is an important part of my job and yours. Working together, we can achieve our goal of safety. Your ideas and safe working practices are important. Make safety everyone's responsibility. I have appointed the vice president as the safety officer. The safety officer will be responsible for development and implementation of the loss control program. Supervisors or branch managers will be responsible for enforcing the plan and establishing safe procedures."

Training for Employees, Supervisors and Managers

An effective loss control program requires job performance from everyone in the workplace.

As an owner or manager, you must ensure that all employees know about the materials and equipment they work with, what known hazards are in the operation and how you are controlling the hazards.

Each employee needs to know the following:

- No employee is expected to undertake a job until he or she has received job instructions on how to do it properly and has been authorized to perform that job.
- No employee should undertake a job that appears unsafe.

You may be able to combine safety and health training with other training that you do, depending upon the kinds of potential and existing hazards that you have. With training, the "proof is in the pudding" in that the result that you want is everyone knowing what they need to know to keep themselves and their fellow workers safe and healthy.

Your own supervisors are the keys to any loss control program and with your support and guidance they can have a direct impact on the reduction of workplace accidents.

New employee orientation should include safety information. Give the new employee a tour explaining the operation, the process and any equipment. Explain any hazards that could lead to injury and the safety precautions to prevent injury.

Here are some other actions to take:

- Ask your state consultant (see State Resources chart) to recommend training for your worksite. The consultant may be able to do some of the training while he or she is there.
- Make sure you have trained your employees on every potential hazard that they could be exposed to and how to protect them. Then verify that they really understand what you have taught them.
- Pay particular attention to new employees and old employees who are moving to new jobs. Because they are learning new operations, they are more likely to get hurt.
- Make sure to train your supervisors to know all the hazards that face the people they supervise and how to reinforce learning with quick reminders and refreshers and with disciplinary action if necessary. Verify that you know what is expected of them.
- Make sure that you and all your top management staff understand all of your responsibilities and how to hold subordinate supervisory employees accountable for theirs.

Safety Analysis

A safety analysis is a means of studying data to determine trends or identify problem areas. It allows you to concentrate on areas of your business that pose the greatest threat to the health and safety of your employees. Two types of analysis you can use:

- Trend analysis
- Job Safety Analysis(JSA)

Trend Analysis

By keeping accident and injury data you can identify particular types of injuries for example: back injuries, and the causes of those injuries (improper lifting or that the injury occurred during lifting operations). Inspection data can reveal problem areas of particular hazards that continually reoccur. The trend analysis may indicate the need for additional training, new procedures, or engineering controls to eliminate the problem(s).

What is Included in the Analysis Component?

To formulate the analysis component, you need to establish in writing:

- Who (by position) is responsible for conducting the analysis.
- What type of analysis will be conducted.
- How often the analysis will be conducted (quarterly, semiannually, annually).
- What data will be analyzed?

What is Trend Analysis?

A trend analysis is a review of statistical data that reveals trends, favorable or unfavorable, that occur as a result of administering your loss control program. It will also identify specific areas where you need to target your loss control efforts. You will want to concentrate on turning unfavorable trends into favorable results.

How Is It Conducted?

To conduct a Trend Analysis, you must:

- Select the data to be analyzed(accident injury data, data of hazards identified during inspections, etc.). Contact your agent/broker for a 3-year history of losses.
- Determine a time period the analysis will cover (monthly, quarterly, or semiannually).
- Identify similarities in data (three out of four accidents involved a back injury, all injuries from the same work area, three out of four involved the same work activities, the same hazards were identified during inspections).
- Develop corrective measures to stop the unfavorable trends.

Job Safety Analysis(JSA)

This process is a means for identifying the hazards associated with a task and applying measures to protect the employee, or to eliminate or control the hazard.

Why conduct a Safety Analysis?

Every company is in business to make a profit. Mistakes or errors that result in damaged products, production delays, or employee accidents impact profits. A simple system of job analysis can help you obtain maximum efficiency, safety and profits.

What is a Job Safety Analysis?

A job safety analysis is a review of job methods that identifies hazards and, with corrective action, results in a safer and more efficient way to do a job. The term "job" refers to the steps or activities involved in a person's occupation. Once job hazards are discovered, proper solutions can be developed.

Some solutions take the form of physical changes that minimize or control job hazards; for example, using machine guards. Other solutions can consist of changes in job procedures that eliminate or minimize hazards; for example, piling materials more safely.

All factors such as quality control, production and safety must be included in the analysis because all of them contribute to a more efficient operation.

OSHA has developed an excellent booklet on how to develop a **Job Safety Analysis** (http://www.osha-slc.gov/Publications/osha3071.pdf) program for your company.

Recordkeeping

There are many reasons for keeping records:

- Employers with more than 10 employees are required by Occupational Safety and Health Administration (OSHA) to maintain records.
- Employers with 10 or fewer employees must maintain records if asked to participate in the Bureau of Labor Statistics annual survey of occupational illness and injuries.
- Some states require all employers covered under workers compensation insurance to keep injury records.
- Records are a source of support for managing your safety program. You need the records to conduct or carry out other safety program components.
- Records may be needed as evidence in legal proceedings or other evidentiary proceedings.
- All employers must report fatalities or accidents resulting in the hospitalization of three or more employees.

Recordkeeping http://www.osha.gov/publications/osha3169.pdf

OSHA logs –Download OSHA 300 Log Form Excel worksheet http://osha.gov/recordkeeping/RKforms.html

Self Inspection: Find and Remove Your Hazards

Most personal injury and property damage in the workplace are caused by unsafe acts of employees and unsafe conditions in the working environment related to tools, equipment or materials.

The management control process for this problem is to find and remove unsafe acts and conditions for your operations. An effective method for doing this is through self-inspections – regularly scheduled, frequent and recorded. The Self-Inspection form included with this document may be used "as is" or tailored to your specific needs. The form not only acts as an inspection guide, but also provides a permanent record for follow-up and corrective action.

What to Include in an Inspection Component

As a small business owner you should identify:

- Who will perform the inspection?
- How often inspections will occur?
- How the inspection will be recorded?
- Who is responsible for reviewing the reports and corrective actions?

Why Make Safety Inspections?

A well-planned safety inspection program helps you detect hazards before an accident occurs. Removing hazards can increase operating efficiency. Using the proper approach, inspectors can convince employees of your concern for their welfare.

When Should Inspections Be Conducted?

Increased production, changes in operations, or installation of new equipment often creates new hazards, such as congestion, poor housekeeping and other conditions that may contribute to employee accidents. Consider scheduling an inspection if any of these changes in conditions occur.

In addition, a periodic inspection program should be established weekly, monthly, or quarterly and then followed up for the best results. It is up to you to determine how often inspections should be conducted.

What to Look For

Both unsafe acts and unsafe conditions contribute to employee accidents. Therefore, these factors should receive special attention. Check your accident record for location and causes of accidents so these can be verified on your inspection. Use an inspection checklist to assist you and add additional items if necessary. A sample checklist is provided to assist you in developing your own.

Accident Investigation

An important part of any loss prevention program is prompt, thorough accident investigation documented in writing. All accidents and incidents in your company should be investigated, no matter how minor the injuries or damage. The unsafe act or condition that causes minor injuries or property damage could just as easily cause a catastrophe under different circumstances.

Finding the cause of an accident is crucial. If the cause is not found, it cannot be removed, and practically guarantees it will happen again.

The Accident Investigation form in this document provides an organized method of investigating accidents involving your employees, plant, tools, equipment or material. It guides you through finding accident causes and taking corrective actions.

What Should Be Included?

Develop employee accident reporting criteria

- Report any accident, no matter how minor the injury, or if only property damage occurs.
- Indicate to whom the accidents are to be reported (supervisors, foremen, etc.)

Employer Reporting Criteria

- OSHA requires that any fatality or accident involving hospitalization of three or more employees must be reported within eight hours.
- OSHA (for employers with more than 10 employees) requires you to report any accident that result from an exposure in the work environment and results in a death or, an illness or an injury that meets any one of the following criteria:

  1. Requires medical treatment other than first aid.
  2. Results in loss of consciousness.
  3. Results in restriction of work or motion.
  4. Leads to transfer to another job.

- Review the regulations and procedures specific to the state(s) you do business in. Many states have specific regulations on the time frame to report accidents in and the forms to use.

Accident Investigation is the process of recording what happened, who was involved, and the resulting injury. It is not conducted to place blame on any individual. It is, however, a means by which you can "zero-in" on the actual cause of the accident so that the necessary corrective action can be taken to prevent recurrence. When investigating an accident, use a standard form so that all aspects of the accident are covered. The following may be helpful:

- Investigate all accidents – even minor accidents may well have serious consequences another time;
- Investigate accidents as soon as possible after they occur while the facts are fresh in everyone's mind;
- Have the persons involved and any witnesses describe the accident as they saw it;
- Avoid jumping to conclusions or placing blame;
- Take corrective action to eliminate the cause and prevent recurrence; and
- Follow-up later to see if the action was satisfactory.

When Should Accidents Be Investigated?

Every accident should be investigated as soon as possible after it occurs. If you wait, facts may be forgotten and evidence could be lost. Prompt investigations get the most complete and useful information. Investigations should take place at the scene of the accident.

Why Should Investigations Be Made?

Accidents don't just happen-they are caused. First, find out what caused the accidents. Second, develop a plan of action to eliminate the cause. All accidents should be investigated, no matter how minor. Eliminating the causes of minor accidents can prevent serious accidents in the future.

Who Should Make Investigations?

You, as owner or manager of the business, should conduct the accident investigation. You know your employees and their jobs better than anyone else does. By conducting the investigations, you demonstrate your concern for the safety of all employees. Therefore, conduct the investigation yourself.

How Should Investigations Be Made?

Effective accident investigation skills are developed through experience. Basically, find out what caused the accident and what can be done to prevent its recurrence. Some suggestions are:

- Check the site and obtain facts before anything has been changed.
- Discuss the accident with the injured employee as soon as possible after first aid or medical treatment has been given.
- Obtain facts from witnesses regarding the conditions and circumstances before and after the accident.
- Compile all facts, no matter how small, to assist you in arriving at the real cause.
- Be objective – the purpose is to find the real cause, not someone to blame.

Now What?

Take the necessary corrective action to eliminate the cause and prevent recurrence. You haven't done a complete job if the cause of the accident is not eliminated or controlled.

- If employee failure was involved, make sure the employee is now properly trained. In addition, make sure to train other employees in similar operations.
- If the operation can be changed to eliminate the hazards, change it.
- Decide if equipment changes or guards are needed. Seek assistance, if necessary, to obtain the proper type of device.
- Follow up on corrective actions to make sure they are effective.

Program Review

A program review or management self evaluation will keep your loss control program current and working efficiently and effectively to prevent accidents, injuries and losses. It is your opportunity to fine tune your program and make adjustments. Conduct a through review of each component. Ensure any new equipment, procedures or operations are incorporated into appropriate components of your plan. Check your existing equipment procedures and operations to ensure that your current component guidelines is meeting your safety needs. Make changes and adjustments in your plan where necessary and don't forget to notify your workers of the changes.

Who Conducts This Review?

Management should designate who is best suited within the company to conduct the review of the Loss Control Program.

When is The Review Conducted?

Management should decide when the review is conducted; however, it is recommended that a review is done at least once a year.

ERGONOMICS

What is ergonomics?

Ergonomics is the science of fitting the job to the worker. When there is a mismatch between the physical requirements of the job and the physical capacity of the worker, ergonomic injuries can result. These injuries are referred to as work related musculoskeletal disorders (WMSDs), cumulative trauma disorders (CTD) or repetitive stress injuries (RSI). (sometimes referred to as work-related musculoskeletal disorders (WMSDs), cumulative trauma disorders (CTD) or repetitive stress injuries (RSI) can result. Workers who must repeat the same motion throughout their workday, who must do their work in an awkward position, who must use a great deal of force to perform their jobs, who must repeatedly lift heavy objects or who face a combination of these risk factors are most likely to develop ergonomic injuries (WMSDs).

How serious a problem are ergonomic injuries (WMSDs)?

In 1996, U.S. workers experienced more than 647,000 lost workdays. WMSDs now account for 34 percent of all lost workday injuries and illnesses. These injuries cost business $15 to $20 billion in workers' compensation costs each year. Indirect costs may run as high as $45 to $60 billion.

Workers who experience WMSDs may be unable to perform their jobs or even simple household tasks. WMSDs represent real workplace problems faced by real people. The scientific basis for the relation between work and development of WMSDs and for addressing ergonomic problems in the workplace is well established.

What can be done to prevent ergonomic injuries (WMSDs)?

Real solutions have been demonstrated in workplaces of all sizes across a broad range of industries. Many employers have developed effective ergonomics programs and common sense solutions to address WMSDs in their workplaces. Often WMSDs can be prevented by simple and inexpensive changes in the workplace. Adjusting the height of working surfaces, varying tasks for workers and encouraging short rest breaks can reduce risks. Reducing the size of items workers must lift or providing lifting equipment also may aid workers. Specially designed equipment, such as curved knives for poultry processors, may help.

What components should an ergonomics program include?

OSHA has identified the following critical elements: management leadership and employee participation, hazard identification and information, job hazard analysis and control, employee training, medical management and program evaluation.

The keys to success are simple: reduce repeated motions, forceful hand exertions, prolonged bending or working above shoulder height. Reduce vibration. Rely on equipment-not backs-for heavy or repetitive lifting. Provide "micro" breaks to allow muscles to recover.

OSHA http://www.osha-slc.gov/SLTC/ergonomics/ and NIOSH http://www.cdc.gov/niosh/ergopage.html have developed some excellent resources that can be used to assist your business in developing or improving your ergonomics program.

Training Requirements in OSHA Standards and Training Guidelines

Many standards promulgated by the Occupational Safety and Health Administration

(OSHA) explicitly require the employer to train employees from the safety and health aspects of their jobs. Other OSHA standards make it the employer's responsibility to limit certain job assignments to employees who are "certified," "competent," or "qualified"—meaning that they have had special previous training, in or out of the workplace. The term "designated" personnel means selected or assigned by the employer or the employer's representative as being qualified to perform specific duties. These requirements reflect OSHA's belief that training is an essential part of every employer's safety and health program for protecting workers from injuries and illnesses. Many researchers conclude that those who are new on the job have a higher rate of accidents and injuries than more experienced workers.

It is usually a good idea for the employer to keep a record of all safety and health training. Records can provide evidence of the employer's good faith and compliance with OSHA standards. Documentation can also supply an answer to one of the first questions an accident investigator will ask: "Was the injured employee trained to do the job?"

Training in the proper performance of a job is time and money well spent, and the employer might regard it as an investment rather than an expense. An effective program of safety and health training for workers can result in fewer injuries and illnesses, better morale, and lower insurance premiums, among other benefits. Readers with questions concerning worker safety and health training should contact their OSHA Regional or Area office. Most of the OSHA training requirements can be found in the publication

Training Requirements in OSHA Standards and Training Guidelines http://www.osha-slc.gov/Publications/osha2254.pdf

Web Resources

State department of Labor OSHA consulting State OSHA Consultants

OSHA - http://www.osha.gov

U.S. Chamber of Commerce http://www.uschamber.org/

Chubb Loss Control Communicators http://www.chubb.com

NHTSA driving http://www.nhtsa.dot.gov/

NSC National Safety Council http://www.nsc.org

U.S. Small Business Administration http://www.sba.gov

NFPA fire protection http://www.nfpa.org

NIOSH http://www.cdc.gov/niosh/homepage.html

ASSE http://www.asse.org

AIHA http://www.aiha.org

University of Vermont http://siri.uvm.edu/

OSHA Handbook for Small Business http://www.osha-slc.gov/Publications/Osha2209.pdf

Information of Drug Free Workplace http://store.health.org/catalog/results.aspx?h=audiences&topic=12

STATE RESOURCES

ALABAMA (205) 348-3033 http://bama.ua.edu/~deip/safe_state_osha.htm	ALASKA (907) 269-4957 http://www.labor.state.ak.us/lss/oshhome.htm	ARIZONA (602) 542-1695 email pat.ryan@osha.gov	ARKANSAS (501) 682-4522 http://www.accessarkansas.org
CALIFORNIA (916) 263-5765 http://www.dir.ca.gov/DOSH/consultation.html	COLORADO (970) 491-6151 http://www.bernardino.colostate.edu/enhealth/7c1.html	CONNECTICUT (860) 566-4550 (860) 566-6916 FAX http://www.ctdol.state.ct.us/osha/osha.htm	DELAWARE (302) 761-8219 http://www.delawareworks.com/divisions/industaffairs/occu.safety.htm
DISTRICT OF COLUMBIA (202) 671-1800 E-mail john.cates3@dc.gov	FLORIDA (866) 273-1105 http://www.safetyflorida.usf.edu	GEORGIA (404) 894-2643 http://www.oshainfo.gatech.edu/	HAWAII (808) 586-9100 http://www.state.hi.us/dlir/hiosh/consult.htm
IDAHO (208) 426-3283 http://www2.boisestate.edu/hes/consultation.htm	ILLINOIS (312) 814-2337 http://www.commerce.state.il.us/bus/index.html	INDIANA (317) 232-2688 http://www.state.in.us/labor/buset	IOWA (515) 281-7629 http://www.state.ia.us/iwd/labor/index.htm
KANSAS (785) 4386 E-mail rudy.leutzinger@osha.gov	KENTUCKY (502) 564-3070 http://www.labor.ky.gov/osh/index.htm	LOUISANA (504) 342-9601 E-mail cmills@idol.state.la.us	MAINE (207) 624-6463 http://janus.state.me.us/labor/consult.htm
MARYLAND (410) 537-4512 http://www.dllr.state.md.us/labor/mosh.html	MASSACHUSETTS (617) 727-3982 http://www.state.ma.us/dos/consult/consult.htm	MICHIGAN (517) 322-1809 http://www.michigan.gov/cis/0,1607,715411407_15317372 96,00.html	MINNESOTA (651) 284-5060 http://www.doli.state.mn.us/mnosha.html
MISSISSIPPI (601) 939-2047 hhht://www.msstate.edu/dept/csh	MISSOURI (573) 751-3403 http://www.dolir.state.mo.us/ls/onsite/index.html	MONTANA (406) 444-6418 http://erd.dli.state.mt.us/safety/Sbhome.htm	NEBRASKA (402) 471-4717 http://www.dol.state.ne.us
NEVADA (702) 486-9140 http://www.4safenv.state.nv.us/	NEW HAMPSHIRE (603) 271-2024 http://www.dhhS.state.nh.us/DHHS/OCCUPATIONHLTH	NEW JERSEY (609)292-3923 http://www.state.nj.us/labor/mainpages/safety.html	NEW MEXICO (505) 827-4230 http://www.state.nm.us/wca/safety.htm
NEW YORK (518) 457-2238 http://www.labor.state.uy.us/html/employer/p469.html	NORTH CAROLINA (919) 807-2899 http://www.nclabor.com	NORTH DAKOTA (701) 328-5188 http://www.ndworkerscomp.com/safety/Default.htm	OHIO (614) 644-2631 http://198.234.41.214/w3/webpo2.usf?Opendatabase
OKLAHOMA (405) 528-1500 http://www.state.ok.us/~okdol/osha/index.htm	OREGON (503) 378-3272 http://orosha.org/	PENNSYLVANIA (800) 382-1241 http://www.hhs.iup.edu/sa/	RHODE ISLAND (401) 277-2438 http://www.state.ri.us/dohrad.htm
SOUTH CAROLINA (803) 734-9614 http://www.lir.state.sc.us/oshavol.htm	SOUTH DAKOTA (605) 688-4101 E-mail james_manning@sdstate.edu	TENNESSEE (615) 741-7155 http://www.state.tn.us/labor-wfd/toshcons.html	TEXAS (512) 804-4640 http://twcc.state.tx.us/services/oshcon.html
UTAH (801) 530-6855 http://www.uosh.utah.gov/Consultation_Services/consultation_services.html	VERMONT (802) 888-0620 http://www.state.vt.us/labind/projectwsindex.htm	VIRGINIA (804) 786-6613 http://www.doli.state.va.us	WASHINGTON (360) 902-5443 http://www.wa.gov/lni/wisha/wisha.htm
WEST VIRGINIA (304) 558-7890 http://www.state.wv.us/labor/	WISCONSIN (1-800-947-0553 http://wisconsafety.com	WYOMING (307) 777-7786 http://wydoe.state.wy.us/doe.asp?ID=7	

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SELF ANALYSIS FORM

This quick "self analysis" will help determine whether your company is in need of a program to improve loss prevention and provides you with an overview of the specific areas in a program that needs improvement.

STATEMENT OF SAFETY POLICY

1

Poor - No statement of policy issued.

Fair - Statement of policy issued but responsibilities not assigned, is generally outdated and is not distributed to new hires.

Good - Statement of policy issued, does include assignment of responsibility, is posted on bulletin board, and has been distributed to all employees, including new hires.

Excellent - In addition to "good," is reviewed, updated and re-distributed annually.

Areas needing attention: _____

SUPERVISORY RESPONSIBILITY WITH ACCOUNTABILITY

2

Poor - Responsibility and accountability for loss prevention not assigned.

Fair - Responsibilities, not well defined in writing and with little accountability.

Good - Responsibilities written and distributed to supervisors with some accountability for performance.

Excellent - Responsibility and accountability emphasized in supervisory performance evaluations, salary administration and promotions.

Areas needing attention: _____

MANAGEMENT INVOLVEMENT

3

Poor - No measurable involvement.

Fair - Occasional follow-up on accident problems.

Good - Management acknowledges good accident experience and takes executive action on poor accident experience. Safety is part of staff meetings.

Excellent - In addition to "good," requires periodic status reports on loss prevention efforts, as well as accident frequency and severity trends. Treats loss prevention the same as every other management responsibility.

Areas needing attention: _____

	EMPLOYEE RESPONSIBILITY
4	**Poor** - Employees not responsible for safety. **Fair** - Employees are generally aware that they are expected to work safely, but their responsibilities are not clearly defined. **Good** - Employees instructed on their loss prevention responsibilities with constant reminders from line supervision. **Excellent** - There is visible evidence of proper concern for safety at the employee level by their attention to safe operating procedures. Areas needing attention: _____
	RULES AND REGULATIONS
5	**Poor** - No written rules or regulations. **Fair** - Plant safety rules have been developed and posted. **Good** - Plant safety rules are incorporated in the plant work rules. **Excellent** - In addition, plant work rules are firmly enforced and updated at least annually. Areas needing attention: _____
	SELF INSPECTION
6	**Poor** - No program to identify and evaluate hazardous practices and/or conditions. **Fair** - Sporadic safety inspections made, but no written reports prepared; little or no follow-up on recommendations. **Good** - Safety inspections conducted on a regular basis. Written reports are prepared, with meaningful recommendations to control unsafe acts and unsafe conditions. Proper follow-up assures completion of recommendations. **Excellent** - In addition to "good," inspection reports are reviewed by top management and compared with corporate results: improved accident record and reduced accident cost. Areas needing attention: _____
	ACCIDENT INVESTIGATION
7	**Poor** - Accidents are not investigated to determine cause and corrective action to prevent recurrence. **Fair** - supervisors investigate Serious accidents. Written reports are not submitted and there is no follow-up on recommendations for corrective action. **Good** - the immediate supervisor investigates All accidents. Written reports are submitted. Accident causes are identified and corrective action taken. Management reviews reports and controls are in place to assure follow-up. **Excellent** - In addition to "good," all accidents (including property damage and no injury incidents) are investigated within 24 hours of occurrence. Areas needing attention: _____

	RECORD KEEPING
8	**Poor** - No accident record keeping. **Fair** - Only major accident records are kept. **Good** - Accident records are maintained for analysis purposes and are used to identify accident causes and provide direction for future loss prevention activities. **Excellent** - Accident causes and damages are graphically illustrated to depict trends and evaluate performance. Management is kept informed. Areas needing attention: _____
	MAINTENANCE
9	**Poor** - No systematic program of maintaining fire protection equipment tools controls and other safety features of facilities, production equipment, etc. **Fair** - Partial, but inadequate or ineffective maintenance. **Good** - Maintenance program for equipment and safety features is adequate with periodic inspections and tests conducted by qualified personnel on a routine basis. **Excellent** - In addition to "good," a preventive maintenance system is programmed and documented for all hazardous equipment and devices. Areas needing attention: _____
	HOUSEKEEPING
10	**Poor** - Housekeeping is generally inadequate. Raw materials work in process and finished stock is improperly stored. Inadequate waste disposal facilities or procedures. **Fair** - Housekeeping is fair. Some attempts are made to adequately store materials. Improvements in waste disposal required. **Good** - Above-average housekeeping and orderly storage of materials; heavy and bulky objects stored out of aisles, etc. Waste disposal is adequately controlled. **Excellent** - Housekeeping, storage of materials and waste disposal are ideally controlled. Areas needing attention: _____
	MATERIAL HANDLING
11	**Poor** - Little attempt to minimize possibility of injury from handling of materials. **Fair** - Partial but inadequate or ineffective attempts at control are in evidence. **Good** - Suitable material handling equipment provided, adequate manpower provided for heavy loads, and employees are properly trained and instructed in safe lifting methods. **Excellent** - In addition to "good," loads are limited in size and shape for manual handling; handling for heavy or bulky loads is automated. Areas needing attention:_____

	GUARDING
12	**Poor** - Little attempt is made to control hazardous points on machinery. **Fair** - Partial but inadequate attempts to control machine hazards are evidenced. **Good** - Control of machine hazards meets minimum Federal and/or State requirements-further improvements needed. **Excellent** - Machine hazards are effectively controlled to the extent that injury is unlikely. Areas needing attention: _____
	PERSONAL PROTECTIVE EQUIPMENT
13	**Poor** - Proper personal protective equipment not provided. **Fair** - Personal protective equipment is inadequate; distribution, maintenance and use of equipment is ineffective. **Good** - Suitable equipment is provided, properly distributed, and well maintained. Use by employees is properly supervised. **Excellent** - In addition to "good," injury record shows the effectiveness of the personal protective equipment program. Areas needing attention: _____
	FIRE PROTECTION
14	**Poor** - Insufficient number or improper type fire extinguishers. Fire extinguisher inspection/service tags out of date. **Fair** - Adequate number and type fire extinguishers, properly mounted, identified, and tagged. **Good** - In addition to "fair," additional fire hoses and/or extinguishers are provided. Welding permits issued. An extinguisher on all welding carts. Adequate evacuation plans. Employees trained in fire extinguisher use. **Excellent** - In addition to "good," building completely sprinklered. Fire brigade or emergency response team organized and trained. Fire drills held. Areas needing attention: _____

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SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

These guidelines help organize the investigation of accidents and incidents involving employees, plant, tools, equipment or material. All accidents and incidents should be investigated, no matter how minor. The same conditions that cause a minor incident could lead to a major accident.

The unsafe acts of workers and the unsafe conditions that cause accidents can be identified and corrected. It is your responsibility to *find* them, *name* them and *correct* them.

PART I - GENERAL INFORMATION

Who was involved _____ Dept._____

A.M.

Date of accident _____ Hour _____ P.M. Exact location _____

Job or activity at time of accident _____

PART II - DESCRIPTION OF ACCIDENT (What Happened)

_____

_____

_____

_____

PART III - WHAT WAS THE CAUSE OF ACCIDENT?

(Determine the cause by analyzing all the factors concerned. If either a person, machine or other physical condition was involved, find out **How** and **Why**)

A. Describe any UNSAFE acts: _____

_____

_____

B. Describe any UNSAFE conditions: _____

_____

	_____ c. FUNDAMENTAL ACCIDENT CAUSE: _____ _____ _____
	PART IV - CORRECTIVE ACTION TAKEN
	(What have you done or what do you recommend to prevent a recurrence of a similar accident? _____ _____ _____ Has it been done? _____ If not, give reason _____ _____

Supervisor	Reviewed and approved by	Date report prepared

INSTRUCTIONS FOR USE OF SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

This form need not be submitted to the insurance company or any government agency.

These steps will help you investigate an accident and fill out the form:

1. Discuss the accident with the employee involved and with any witnesses. Be sure to question the why-what-where-when-who-how aspects of the accident.
2. Inspect the equipment or materials involved for conditions that could be made safer.
3. Study the job set-up and process of doing the work. Could it be improved?
4. Is the employee involved suited for the job he/she is doing? Did he/she receive adequate training? Are there any other contributing problems-use of drugs, use of alcohol, or emotional problems?
5. Recommendations to correct the problem must be practical. Be sure your recommendations will not create other situations, which could result in injury to employees.
6. Complete your report no later than the next working day after the accident.

EXAMPLES OF ACCIDENT CAUSES

UNSAFE ACTS- PERSONAL FACTORS	UNSAFE CONDITIONS	FUNDAMENTAL CAUSES
Making safety devices inoperable	Inadequate guards or protection	Inadequate hiring standards
Failure to use guards provided	Detective tools or equipment	Inadequate job placement standard
Using defective equipment	Unsafe condition of machine	Lack of proper procedures
Servicing equipment in motion	Congested work area	Inadequate job instruction
Failure to use proper tools or Equipment	Poor housekeeping	Inadequate enforcement of work standards
Operating machinery or equipment at unsafe speed	Unsafe floors, ramps, stairways, platforms	Inadequate supervision
Failure to use the personal protective equipment	Improper material storage	Inadequate job planning methods
Operating without authority	Inadequate warning system	Inadequate preventative maintenance program
Lack of skill or knowledge	Fire or explosion hazards	Inadequate maintenance standards
Unsafe loading or placing improper lifting, lowering or carrying	Hazardous atmosphere: gases, dust, fumes, vapors	Improper layout or design
Taking unsafe position	Hazardous substances	Unsafe design or construction
Improper lifting, lowering or carrying	Inadequate ventilation	Inadequate purchasing standards
Taking unsafe position	Radiation exposures	Inadequate environmental control program
Unnecessary haste	Excessive noise	
Influence of alcohol or drugs	Inadequate illumination	
Physical limitation or mental attitude		
Unaware of hazards		
Unsafe act of other		

This form provides a structured method for evaluating potential accident causes in your company. It should be used on a regular and frequent basis, either as is or tailored to your specific needs. The form also provides a permanent record for monitoring follow-up activity

Date:_____

Inspected by:_____

_____

HOUSEKEEPING	YES	NO
Are all aisles clearly marked	☐	☐
Are all aisles clear	☐	☐
Are all floors clear of tripping		
Hazards (hoses, wires, pipes, etc.)	☐	☐
Are all floors free of slipping hazards		
(oil, grease, sand, etc.)	☐	☐
Is all stock neatly arranged	☐	☐
Are suitable containers provided for		
Waste materials and trash	☐	☐
Are there any combustible trash		
Accumulations outside of proper		
Containers	☐	☐
Are flammable liquids safely handled		
and stored	☐	☐
Area combustible packing materials		
kept in safe containers and is the		
Packing area cleaned up at closing		
Time	☐	☐
Is storage in warehouse orderly with		
Ample aisle space	☐	☐

HAZARDOUS MATERIALS	YES	NO
Are all gas cylinders:		
1. Labeled	☐	☐
2. Secured	☐	☐
3. Capped	☐	☐
Are all flammables in safety cans	☐	☐
Are all cans/containers:		
1. Labeled	☐	☐
2. In good condition	☐	☐
Are acids & flammables separated	☐	☐
Are bulk flammables stored in		
Separate room/cabinet	☐	☐
Is room/cabinet in good condition	☐	☐
Are all metal drums grounded in		
Flammable storage room	☐	☐

HAZARDOUS WASTE CONTAINER STORAGE	YES	NO
Are hazardous wastes being		
Accumulated	☐	☐
Are labels clearly marked, dated	☐	☐
Are drums in good condition		
(covered, clear of obstruction, no leaks)	☐	☐

MACHINE GUARDING	YES	NO
Are all points of operation adequately		
Guarded	☐	☐
Are all drive mechanisms adequately		
Guarded	☐	☐
Are all interlocks operational	☐	☐

PERSONAL PROTECTIVE EQUIPMEN		
(Gloves, Glasses, Hearing Protection)	**YES**	**NO**
Is protective equipment available	☐	☐
Is protective equipment in good condition	☐	☐
Is protective equipment usage enforced	☐	☐
Are all required employees wearing their		
Equipment	☐	☐

ELECTRICAL EQUIPMENT	YES	NO
Is electrical equipment grounded	☐	☐
Are all wires securely fastened	☐	☐
Area all wires in good condition	☐	☐
Are all electrical boxes covered	☐	☐
Is there any temporary wiring	☐	☐

LADDERS	YES	NO
Are the following ladder parts in good		
Condition:		
Rungs-Steps	☐	☐
Hinges	☐	☐
Rubber Cleats	☐	☐
Frame	☐	☐
Are ladders adequate in height	☐	☐

EGRESS	YES	NO
Is emergency lighting operational	☐	☐
Are all exists clear	☐	☐
Do all exits have signs	☐	☐
Are all signs lit	☐	☐

SAFETY EQUIPMENT & MISC.	YES	NO
(covered, clear of obstruction, no leaks)	☐	☐
Does spill station contain all listed		
Materials	☐	☐
Volume of waste (#drums, or level		
in inches)	☐	☐
Have hazardous spill clean-up		
Procedures been established	☐	☐
Is the proper absorbent material for spills available	☐	☐
Is all waste tightly sealed	☐	☐

UNSAFE PRACTICES	YES	NO
Are forklifts in good operating order	☐	☐
Are forklifts driven safely		
Is lifting done correctly	☐	☐

SMOKING	YES	NO
Are there designated areas for smoking	☐	☐
Are "No Smoking" regulations enforced		
in restricted areas	☐	☐

SPRINKLER SYSTEM	YES	NO
Are all sprinkler control valves open	☐	☐
Are any sprinklers obstructed by partitions		
or high-piled storage	☐	☐
Are there any areas where sprinklers are		
Needed	☐	☐
Are there any areas where sprinklers may		
be subject to freezing	☐	☐
Do all sprinkler water flow alarms operate		
Satisfactorily	☐	☐
Are any sprinkler heads painted, corroded		
or loaded	☐	☐
Is air pressure adequate on all dry pipe		
sprinkler systems	☐	☐

Are all eyewash/showers accessible	☐	☐
Do all eyewash/showers work	☐	☐
Are pressure gauges indicating		
Sufficient pressure	☐	☐
Is all venting operating	☐	☐
Are all lights lit	☐	☐
Is there sufficient lighting	☐	☐
Are all First Aid kits stocked	☐	☐
Is self-contained breathing apparatus		
Inspected	☐	☐
FIRE DOORS	**YES**	**NO**
Are all fire doors in good condition,		
Operable, unobstructed and not blocked		
Open	☐	☐
Area automatic closing devices in		
Operating condition	☐	☐

Are all dry pipe valve enclosures heated		
Sufficiently to prevent freezing	☐	☐
HYDRANTS	**YES**	**NO**
Are all hydrants accessible and		
Unobstructed	☐	☐
Are all hydrants in good operating		
condition and do they drain properly	☐	☐
FIRE EXTINGUISHERS AND SMALL		
HOSE (1-1/2 in.)	**YES**	**NO**
Are all extinguishers properly charged		
and pressurized	☐	☐
Are all extinguishers and small hoses		
in good condition and readily accessible	☐	☐

GENERAL IMPRESSIONS/CONDITIONS REQUIRING ATTENTION (Identify location)

CORRECTIVE ACTION BEING TAKEN

CHUBB

NOTICE TO INSUREDS

The State of California requires employers to provide the attached pamphlet, "Facts About Workers Compensation", to all new employees at the time of their employment.

You can order additional pamphlets by contacting the California Worker's Compensation Institute at (510) 251-9470, or through their website located at:

www.cwci.org

When you enter the site, click on Bookstore and select Pamphlets and Posting Notices. Select the applicable pamphlet - Facts About Workers' Compensation - and scroll to the bottom of the screen to order.

Posting Notice

EMPLOYEE MPN INFORMATION

This information is being provided to you to explain your rights and responsibilities should you have an accident at work. You will also receive a copy of this notice at the time of injury.

- The California Workers' Compensation Regulation requires employees to utilize the Medical Provider Network (doctors, hospitals, ancillary services) who are part of a Medical Provider Network or MPN. The Medical Provider Network has been selected for treatment of **work related injuries.**

Employer Contact:
Contact Name: Jacob Seehoffer **Telephone Number: 800.966.5307**
Address: 600 City Parkway West
City, State, Zip: Orange, CA 92868

If you are injured on the job...

1. Report your injury to your supervisor/manager *immediately.*
   IN CASE OF EMERGENCY SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST EMERGENCY FACILITY.
2. You may be asked to provide information such as....
   - Your Name
   - Your Home Address, City, State, Zip, County, Telephone Number
   - Date of Birth
   - Social Security Number
   - Date, Time, Location and Nature of Injury
3. If you require medical treatment, A **Medical Provider Network physician** (or other health care provider) is available for you to see. The MPN network provider will become your primary care physician and will provide the necessary and appropriate treatment for your work related injury. Your primary care physician will direct your care overall and refer to specialists as required within the MPN. A **CorVel** nurse may be assigned to interact with you, your provider and employer. The MPN network, listing of the health care providers, is available from your employer MPN contact person, your claims adjuster, or online at www.corvel.com – under "Employees" heading, choose California from the drop down box. At any time you are choosing a physician, you have the right to select from the entire MPN.
4. If you are on Business-Related Travel or away from your work site when an injury occurs, call your supervisor/manager to report your injury immediately. They will help you in seeking medical attention. **In case of emergency seek immediate medical attention at the nearest emergency facility.**
5. If you are traveling, or now live outside the MPN geographical area, you will be supplied with at least three physicians within the access standards to choose from for your medical treatment. If there are not three MPN physicians within the access standards available to treat you, you may be allowed to use a non-MPN provider. You have the right to change physicians and obtain a 2nd or 3rd opinion from among the referred physicians.
6. You may only use physicians within the MPN. See exceptions in Transfer of Care and Continuity of Care policies.
7. If you are having trouble scheduling an appointment with a provider within the MPN, contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in getting an appointment scheduled for you.
8. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist.
9. Appointments for initial treatment will be available within 3 business days of your request. Non-emergency appointments with specialists will be available within 20 business days or receipt of referral.

ADDITIONAL INFORMATION REGARDING YOUR RIGHTS UNDER THE CALIFORNIA MPN.
You will be provided notification upon transfer into the MPN. You may go to a specialist outside the MPN if your primary treating MPN physician refers you to a specialist outside the network. You may also choose your own specialist from within the MPN network independent of any referral by your treating physician or provider.

CORVEL

INFORMACION DEL EMPLEADO SOBRE LA MPN

Se le brinda esta información para explicarle sus derechos y responsabilidades y lo que debe hacer si se accidenta en el trabajo. Usted también recibirá una copia de este aviso a la hora de lesión.

- La Regulación de Compensación Laboral de California requiere que empleados utilicen la Red de Proveedores Médicos (médicos, hospitales, servicios auxiliares) que son parte de una Red de Proveedores Médicos, sea, una MPN. La Red de Proveedores Médicos ha sido seleccionada para **tratamiento de lesiones ocasionadas en el trabajo**.

Contacto del Empleador:
Nombre del Contacto: Jacob Seehoffer **Número de Teléfono: 800.966.5307**
Dirección: 600 City Parkway West
Ciudad, Estado, Código Postal: Orange, CA 92868

Si usted se lesiona en el trabajo...

1. Reporte *inmediatamente* su lesión a su supervisor/gerente.
   EN CASO DE EMERGENCIA, BUSQUE ATENCION MEDICA INMEDIATA EN EL MÁS CERCANO CENTRO DE EMERGENCIA.
2. Le pueden pedir información tal como....
   - Su Nombre
   - Su Dirección, Ciudad, Estado, Código Postal, Condado, Número de Teléfono
   - Fecha de Nacimiento
   - Número de Seguro Social
   - Fecha, Hora, Lugar y Naturaleza de la Lesión
3. Si usted requiere tratamiento medico, un **médico de la Red de Proveedores Médicos** (u otro proveedor de cuidado médico) está disponible para atenderlo. El proveedor de la red MPN se hará su médico de cabecera y le brindará el tratamiento necesario y apropiado para su lesión ocasionada en el trabajo. Su médico de cabecera se encargará de su cuidado completo y hará referencias a especialistas como se requiera dentro del MPN. Una enfermera CorVel puede ser asignada para comunicarse con usted, su proveedor y empleador. Una lista de proveedores de servicios médicos de la red MPN está disponible de la persona contacto de la MPN de su empleador, de su ajustador de reclamos, o en línea en www.corvel.com - bajo el titulo "Empleados" escoja California de la caja ascendente. En cualquier momento cuando usted está eligiendo un medico, usted tiene el derecho de seleccionar del MPN entero.
4. Si usted se encuentra en un Viaje Relacionado al Trabajo o está fuera de su lugar de trabajo cuando ocurre una lesión, llame inmediatamente a su supervisor/ gerente para reportar su lesión. Ellos lo ayudarán a buscar atención médica. **En caso de emergencia, busque atención médica inmediata en el centro de emergencia más cercano.**
5. Si usted viaja o vive fuera de la área geográfica del MPN, usted será proporcionado por lo menos tres médicos para elegir su tratamiento médico dentro del reglamento que escoja de su tratamiento médico. Si en caso no hay tres medico del MPN dentro del reglamento disponible para tratarlo a usted, usted ce le permitirá a usar un proveedor accesible que no es de MPN. Usted tiene el derecho de cambiar médicos y obtener una segunda o tercer opinión dentro de los médicos recomendados.
6. Usted solo puede utilizar a médicos dentro de la MPN. Vea las excepciones en la Transferencia de Cuidado y Continuidad de Cuidado.
7. Si usted tiene problemas en programar una cita con un proveedor dentro de la MPN, comuníquese con el contacto de la MPN de su empleador, ajustador de reclamos, o gerente de casos, si es asignado, para que asistencia en programar una cita.
8. Si usted requiere referencia a un especialista (ortopédico, dermatólogo, etc.), comuníquese con el contacto de la MPN de su empleador, ajustador de reclamos, o su gerente de casos, si es asignado, para que le ayuden a seleccionar y programar una cita con un especialista.
9. Citas para tratamiento inicial serán disponibles dentro de 3 días hábiles de su solicitud. Citas con especialistas sin emergencia serán disponibles dentro de 20 días hábiles o al recibir la referencia.

INFORMACIÓN ADICIONAL CON RESPECTO A LAS SUS DERECHAS DEBAJO DE LA CALIFORNIA MPN.
Usted será notificación proporcionada sobre transferencia en el MPN. Usted puede ir a un especialista fuera del MPN si su médico primario del MPN que trata le refiere a un especialista fuera de la red. Usted puede también elegir a su propio especialista dentro de la independiente de la red del MPN de cualquier remisión por su médico o abastecedor que trata.

CORVEL

EMPLOYEE REQUEST FOR A SECOND/THIRD MEDICAL OPINION

You have the opportunity to request and obtain a second and a third medical opinion within the provider network if you have a disagreement with the treatment or diagnosis. During this process, you must continue to receive your treatment with your current treating physician, or another provider of your choice within the MPN. To view the entire list of MPN providers, you may log onto www.corvel.com as described in page 1, number 3. This process is as follows:

1. If you disagree with the treatment plan or diagnosis you can request a 2nd or 3rd medical opinion.
2. A request is generated from the employee either by phone or in writing to the Claims Adjuster.
3. The request is received by the Claims Adjuster who will provide a regional area listing of providers within the network for you to choose from. At any time you have the right to choose a physician from the entire MPN network or from the list provided.
4. You must schedule an appointment with one of the physicians from the supplied list or from the entire MPN within (60) sixty days, or it shall be deemed that you have waived your right to the second opinion process with regard to this disputed diagnosis or treatment. At any time you are choosing a physician, you have the right to select from the entire MPN.
5. Once you have obtained an appointment, you must notify your claims adjuster of the physician, the appointment date and time.
6. If the appointment is not made within 60 days of receipt of the list of available MPN providers, then you shall be deemed to have waived the second and/or third opinion process.
7. During this process, you are required to continue your treatment with the treating physician or a physician of your choice within the MPN.
8. If the 2nd or 3rd opinion physician determines that your injury is outside the scope of their practice, you will be provided with a new list of MPN providers and/or specialists.
9. If you disagree with the 2nd opinion, then you can request a 3rd opinion and follow Steps 2-5 as above.
10. If you disagree with the diagnosis or treatment of the third opinion physician, you may request an Independent Medical Review. At the time you request a third opinion, your employer, MPN contact or adjuster will give you information on requesting an Independent Medical Review and the form.
11. At the time of your selection of your third opinion physician, you will be supplied with information on how to request an independent medical review, along with an application for Independent Medical Review for you to complete, should you disagree with the third opinion.
12. The claims adjuster will contact the treating physician, provide a copy of the medical records or send the necessary records to the second and/or third opinion physician prior to the appointment date. Upon your request, you can receive a copy of the medical records from your claims adjuster.
13. The second/third opinion physician will be notified in writing that he or she has been selected to provide a second/third opinion and the nature of the dispute with a copy to you.
14. A copy of the written report shall be provided to the employee, the person designated by the employer or insurer, and the treating physician within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.
15. You may obtain the recommended treatment within the MPN. If you choose you may obtain the recommended treatment by changing physicians to the second opinion physician, third opinion physician, or another MPN physician.

CHANGING YOUR PHYSICIAN

You are allowed to change to another provider if you would like to change providers for any other reason than listed above under Employee Request for a Second/Third Opinion. Your request may be directed to your Nurse case Manager or your Claims Adjuster. The provider must be within the Medical Provider Network. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist. The specialist you choose can be from the entire MPN.

SOLICITUD DEL EMPLEADO PARA UNA SEGUNDA/TERCERA OPINIÓN MÉDICA

Usted tiene la oportunidad de solicitar y obtener una segunda y una tercera opinión médica dentro de la red de proveedores si usted no está de acuerdo con el tratamiento o diagnóstico. Durante este proceso, usted debe seguir recibiendo su tratamiento de su médico tratante actual, u otro proveedor que usted escoja dentro de la MPN. Para ver la lista entera de los proveedores, usted puede ir a www.corvel.com como se describe en pagina 1, numero 3.
Este proceso es así:

1. Si usted no está de acuerdo con el plan de tratamiento o el diagnóstico, puede solicitar una segunda o tercera opinión médica.
2. Una solicitud es creada del empleado por teléfono o por escrito al Ajustador de Reclamos.
3. La solicitud es recibida por el Ajustador de Reclamos que proveerá una lista regional de área de los mismos proveedores dentro de la red que están disponibles para su selección. En cualquier momento, usted tiene el derecho de escoger a un médico de la red entera de MPN o de la lista proporcionada.
4. Usted debe programar una cita con uno de los médicos de la lista brindada o de la lista MPN dentro de (60) sesenta días, se considerará que usted ha renunciado su derecho al proceso de segunda opinión con relación al diagnóstico o tratamiento disputado. En cualquier momento cuando usted está eligiendo un medico, usted tiene el derecho de seleccionar del MPN entero.
5. Una vez usted ha obtenido una cita, debe notificar al ajustador de reclamos sobre el médico, fecha y hora de la cita.
6. Si la cita no esta hecha dentro de 60 días de recibir la lista de proveedores disponibles del MPN, entonces usted se le considera deber renunciado al proceso de la segunda y o tercer opinión.
7. Durante este proceso, usted esta requerido ha continuar su tratamiento con el médico de trata o el médico de su elección dentro del MPN.
8. Si los médicos de la segunda o tercer opiniones determinan que su lesión esta fuera del alcance de practica, se le proveerá una lista nueva de proveedores del MPN y o especialistas.
9. Si usted no está de acuerdo con la segunda opinión, puede solicitar una tercera opinión, siguiendo los Pasos 2 – 5 antedichos.
10. Si usted no está de acuerdo con el diagnóstico o tratamiento del médico de la tercera opinión, puede solicitar una Revisión Médica Independiente. A la vez de solicitar la tercer opinión, su empleador, el contacto del MPN o su ajustador le dará la información de como solicitar la Revisión Medica Independiente y la forma de solicitud.
11. A la vez de su selección de su medico de tercer opinión, se le proporcionara con información de como solicitar una revisión medica independiente, con la solicitud para una Revisión Medica Independiente para que usted llene, si es que usted no esta de acuerdo con la tercer opinión.
12. El ajustador de reclamos contactará al médico que trata, proporcionarle una copia de los registros médicos o enviará los registros necesarios al segundo y/o tercer médico de la opinión antes de la fecha de nombramiento. Sobre su pedido, usted puede recibir una copia de los registros médicos por medio de su ajustador de reclamación.
13. El segundo/tercer médico de la opinión será notificado por escrito que él o ella han sido escogidos para proporcionar una segundo/tercer opinión y la razón de la disputa con una copia a usted.
14. Una copia del informe escrito será proporcionado al empleado, la persona designada por el empleador o el asegurador, y al médico que trata dentro de 20 días de la fecha del nombramiento o al recibir los resultados de las pruebas diagnósticas, el que es más tarde.
15. Usted puede obtener el tratamiento aconsejado dentro del MPN. Si usted le elige puede obtener el tratamiento aconsejado cambiando a médicos al segundo médico de la opinión, a tercer médico de la opinión, o a otro médico de MPN.

CAMBIANDO A SU MÉDICO

A le se permite cambiar a otro abastecedor si usted quisiera cambiar los abastecedores por cualquier otra razón que enumerada arriba bajo petición del empleado para una segunda/tercero opinión. Su petición se puede dirigir a su encargado del caso de la enfermera o a su ajustador de demandas. El abastecedor debe estar dentro de la red médica del abastecedor. Si usted requiere una remisión a un especialista, (ortopedista, dermatologist, etc.), entre en contacto con a su contacto del MPN del patrón, al ajustador de demandas, o a su encargado del caso, si está asignado, para la ayuda en seleccionar y programar una cita con un especialista. El especialista que usted elige puede ser del MPN entero.

TRANSFER OF ONGOING CARE INTO MPN

If you are being treated for an occupational injury or illness by a physician or provider prior to your enrollment into your employer's medical provider network (MPN), and your physician or provider becomes a provider or already is an MPN provider, the MPN/employer will notify you that your treatment is being provided by your physician or provider under the provisions of the MPN. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the MPN coverage effective date.

A dispute resolution policy is included in the Transfer of Ongoing Care policy. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN.

ACCESS STANDARDS

You have a right to access to MPN providers that are located within reasonable distances of your residence or workplace. The MPN must have a primary care physician and a hospital for emergency care within 30 minutes or 15 miles of your residence or workplace and providers of occupational health services and specialists within 60 minutes or 30 miles of your residence or workplace. If at any time you reside or work in a portion of the service area in which health care facilities are located outside the MPN access standards, the employer or MPN treating physician will assist the you in identifying a minimum of three (3) non-MPN providers in the specialty needed and within the access standard distance." If there are not three (3) providers in the needed specialty within the access standard distance you may choose a non-MPN provider.

CONTINUITY OF CARE

If you are treating in a medical provider network and the provider is terminated from participation in the MPN network, you have certain rights to continue your treatment with this terminated provider subject to the conditions set forth in your employer's Continuity of Care policy. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

A dispute resolution policy is included in the Continuity of Care policy. You may request a complete copy of the Continuity of Care policy from your employer or MPN.

LA TRANSFERENCIA DEL CUIDADO EN CURSO EN EL MPN

Si a un médico le está tratando para lesión o una enfermedad ocupacional o un abastecedor antes de su inscripción en la red médica del abastecedor de su patrón (MPN), y su médico o abastecedor se convierte en abastecedor o es ya abastecedor del MPN, el MPN/employer le notificará que su tratamiento está siendo proporcionado por su médico o abastecedor bajo provisiones del MPN. Usted puede solicitar una copia completa de la transferencia de la política en curso del cuidado de su patrón o MPN. Algunas circunstancias que pueden permitir el tratamiento continuado con el abastecedor terminado incluyen una condición aguda, una condición crónica seria, una enfermedad terminal, o funcionamiento de la cirugía o del otro procedimiento que es autorizado por el asegurador o el patrón como parte de un curso del tratamiento documentado y ha sido recomendado y documentado por el abastecedor para ocurrir en el plazo de 180 días de la fecha eficaz de la cobertura del MPN.

Una política de la resolución del conflicto se incluye en la transferencia de la política en curso del cuidado. Usted puede solicitar una copia completa de la transferencia de la política en curso del cuidado de su patrón o MPN.

LOS ESTÁNDARES DEL ACCESO

Usted tiene una derecha de tener acceso a los abastecedores del MPN que están situados dentro de distancias razonables de su residencia o lugar de trabajo. El MPN debe tener un médico primario del cuidado y un hospital para el cuidado de la emergencia en el plazo de 30 minutos o 15 millas de su residencia o lugar de trabajo y abastecedores de los servicios de la medicina del trabajo y especialistas a 60 minutos o a 30 millas de su residencia o lugar de trabajo. Si usted reside o trabaja en cualquier momento en una porción del área de servicio en la cual las instalaciones del cuidado médico están situadas fuera de los estándares del acceso del MPN, el patrón o el MPN que trata a médico le asistirá en identificar a un mínimo de tres (abastecedores 3) no-MPN en la especialidad necesitada y dentro de la distancia del estándar del acceso." Si no hay tres (3) abastecedores en la especialidad necesaria dentro de la distancia estándar del acceso usted puede elegir un abastecedor no-MPN.

CONTINUIDAD DEL CUIDADO

Si usted está tratando en una red médica del abastecedor y el abastecedor se termina de la participación en la red del MPN, usted tiene ciertas derechas de continuar su tratamiento con este abastecedor terminado conforme a las condiciones dispuestas en la continuidad de su patrón de la política del cuidado. Algunas circunstancias que pueden permitir el tratamiento continuado con el abastecedor terminado incluyen una condición aguda, una condición crónica seria, una enfermedad terminal, o funcionamiento de la cirugía o del otro procedimiento que es autorizado por el asegurador o el patrón como parte de un curso del tratamiento documentado y ha sido recomendado y documentado por el abastecedor para ocurrir en el plazo de 180 días de la fecha de la terminación del contrato.

Una política de la resolución del conflicto se incluye en la continuidad de la política del cuidado. Usted puede solicitar una copia completa de la continuidad de la política del cuidado de su patrón o MPN.

EMPLOYEE INFORMATION ON THE

INDEPENDENT MEDICAL REVIEW PROCESS

This notice is to inform you of your rights, responsibilities and process in obtaining an Independent Medical Review (IMR). If you disagree with your treatment plan or diagnosis that the third opinion physician rendered, you have the right to request an Independent Medical Review. At the time you request a physician for a third opinion, your MPN contact or Claims Adjuster will provide you with this form covering the Independent Medical Review process. You will also be provided with an "Application for Independent Medical Review" form. The MPN contact or Claims Adjuster will fill out the "MPN Contact section" for you. You will need to complete the "employee section" of the form, indicate on the form whether you are requesting an in-person examination or a records review. You may also list an alternative specialty, if any, that is different from the specialty of the treating physician.

The Administrative Director will select an IMR with an appropriate specialty within 10 business days of receiving your Application for Independent Medical Review form. The Administrative Director's selection of the IMR will be based on the specialty of your treating physician, the alternative specialties listed by you and the MPN contact, and the information submitted with the Application for Independent Medical Review.

If you request an in-person examination, the Administrative Director will randomly select a physician from a list of available independent medical reviewers, with an appropriate specialty, who has an office located within thirty miles of your residential address, to be your independent medical reviewer. If there is only one physician with an appropriate specialty within thirty miles of your residential address, that physician shall be selected to the independent medical reviewer. If there are no physicians with an appropriate specialty who have offices located within thirty miles of your residential address, the Administrative Director will search in increasing file mile increments, until one physician is located. If there are no available physicians with this appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

If you request a record review, then the Administrative Director will randomly select a physician with an appropriate specialty from the list of available independent medical reviewers to be the IMR. If there are no physicians with an appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

The Administrative Director will send written notification of the name and contact information of the IMR to you, your attorney, if any, the MPN contact and the IMR. The Administrative Director will send a copy of the completed Application for Independent Medical Review to the IMR.

You, the MPN Contact, or the selected IMR can object within 10 calendar days of receipt of the name of the IMR to the selection if there is a conflict of interest as defined by section 9768.2. If the IMR determines that they do not practice the appropriate specialty, the IMR shall withdraw within 10 calendar days of receipt of the notification of selection. If the conflict is verified or the IMR withdraws, the Administrative Director will select another IMR from the same specialty. If there are no available physicians with the same specialty, the Administrative Director may select an IMR with another specialty based on the information submitted and in accordance with the procedure set forth for an in-person examination and for a records review.

If you request an in-person examination, within sixty calendar days of receiving the name of the IMR, you must contact the IMR to arrange an appointment. If you fail to contact the IMR for an appointment with sixty calendar days of receiving the name of the IMR, then you will be deemed to have waived the IMR process with regard to this disputed diagnosis or treatment of this treating physician. The IMR shall schedule an appointment with you within thirty calendar days of the request for an appointment, unless all parties agree to a later date. The IMR shall notify the MPN contact of the appointment date.

Should you decide to withdraw the request for an independent medical review, you need to provide written notice to the Administrative Director and the MPN contact.

During this process, the employee shall remain within the MPN for treatment pursuant to section 9767.6.

The MPN Contact shall send all relevant medical records to the IMR. The MPN Contact shall also send a copy of the documents to the covered employee. The employee may furnish any relevant medical records or additional materials to the Independent Medical Reviewer, with a copy to the MPN contact as set forth in 8 CCR Section 9768.11(a). If you have requested an in-person examination and a special form of transportation is required because of your medical condition, the MPN contact will arrange it for you. The MPN Contact shall furnish transportation and arrange for an interpreter, if necessary, in advance of the in-person examination. All reasonable expenses of transportation shall be incurred by the insurer or employer pursuant to Labor Code section 4600. Except for the in-person examination itself, the independent medical reviewer shall have no ex parte contact with any party. Except for matters dealing with scheduling appointments, scheduling medical tests and obtaining medical records, all communications between the independent medical reviewer and any party shall be in writing with copies served on all parties.

If the IMR requires further tests, the IMR shall notify the MPN Contact within one working day of the appointment. All tests shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and for all injuries not covered by the medical treatment utilization schedule or the ACOEM guidelines, in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

INFORMACIÓN DEL EMPLEADO SOBRE EL PROCESO DE LA REVISIÓN MÉDICA INDEPENDIENTE

Este aviso es para informarle de sus derechos, responsabilidades y el procedimiento a obtener una Revisión Medica Independiente o Independent Medical Review (IMR). Si usted no esta de acuerdo con su plan de tratamiento o el diagnóstico que el tercer médico de opinión rindió, usted tiene el derecho de solicitar una Revisión Medica Independiente o Independent Medical Review (IMR). Cuando usted solicite a un médico para una tercera opinión, su contacto del MPN o ajustadora de reclamos le proporcionará con esta forma que cubre el procedimiento de Una Revisión Medica Independiente o Independent Medical Review (IMR). Usted será proporcionado también con una forma "Solicitud para Una Revisión Medica Independiente o Independent Medical Review (IMR)". El contacto de MPN o Ajustadora de reclamos le llenará "la sección de MPN Contact". Usted necesitará completar "la sección de empleado" de la forma, indique en la forma si usted solicita un examen en-persona o una revisión de registros. Usted puede listar también una especialidad alternativa, si es distinta de la especialidad del médico de tratamiento.

El Director Administrativo (Administrative Director) escogerá un IMR con una especialidad apropiada dentro de 10 días hábiles de recibir la forma de solicitud para una Revisión Medica Independiente o Independent Medical Review (IMR). La selección del Director Administrativo sobre el IMR se basará en la especialidad de su médico de tratamiento, las especialidades alternativas en la lista escogidos por usted y por el contacto de MPN, y la información sometida con la Solicitud para obtener una Revisión Medica Independiente o Independent Medical Review (IMR).

Si usted solicita un examen en-persona, el Director Administrativo escogerá al azar un médico de una lista de médicos crítico s independientes y disponibles, con una especialidad apropiada, que tenga una oficina localizada dentro de treinta millas de su dirección residencial, para ser su médico crítico independiente. Si hay sólo un médico con una especialidad apropiada dentro de treinta millas de su dirección residencial, ese médico será escogido a ser el medico crítico independiente. Si no hay médicos con una especialidad apropiada que tenga las oficinas localizadas dentro de treinta millas de su dirección residencial, el Director Administrativo aumentará el incremento de milla de archivo, hasta que un médico sea localizado. Si no hay médicos disponibles con esta especialidad apropiada, el Director Administrativo puede elegir otra especialidad basada en la información sometida.

Si usted solicita una revisión del registro, entonces el Director Administrativo al azar escogerá un médico con una especialidad apropiada de la lista de médicos crítico s independientes y disponibles para ser el IMR. Si no hay médicos con una especialidad apropiada, el Director Administrativo puede elegir otra especialidad basada en la información sometida.

El Director Administrativo le enviará notificación en escrito del nombre de y la información de contacto del IMR ha usted, su abogado, si es que lo tiene, al contacto de MPN y al IMR. El Director Administrativo enviará una copia de la solicitud terminada para obtener una Revisión Medica Independiente o Independent Medical Review (IMR).

Usted, el contacto del MPN, o el IMR escogido pueden oponerse a la selección dentro de 10 días de calendario después de recibir del nombre del IMR, si hay un conflicto de intereses como definido por la sección 9768,2. Si el IMR determina que ellos no practican la especialidad apropiada, el IMR retirará la selección dentro de 10 días de calendario de recibir la notificación de la selección. Si el conflicto se verifica o el IMR se retira, el Director Administrativo escogerá otro IMR de la misma especialidad. Si no hay médicos disponibles con la misma especialidad, el Director Administrativo puede escoger un IMR con otra especialidad basada en la información sometida y de acuerdo con el conjunto de procedimiento establecido para un examen en-persona y para una revisión de registros.

Si usted solicita un examen en-persona, dentro de sesenta días de calendario después de recibir el nombre del IMR, usted debe contactar el IMR para hacer una cita. Si usted falla en contactar al IMR para hacer una cita dentro de sesenta días de calendario después de recibir el nombre del IMR, entonces será considerado de haber renunciado al procedimiento de IMR con respecto a este diagnóstico o el tratamiento disputado de su médico de tratamiento. El IMR fijará una cita con usted dentro de treinta días de calendario después del pedido de la cita, al menos de que todos los interesados concordarán a una fecha mas adelante. El IMR notificará el contacto de MPN de la fecha de la cita.

Si usted decide retirar el pedido para una revisión médica independiente, usted necesita proporcionar un aviso en escrito al Director Administrativo y al contacto del MPN.

Durante este proceso, el empleado permanecerá dentro del MPN para el tratamiento conforme a la sección 9767.6.

El contacto del MPN enviara todos los expedientes médicos relevantes al IMR. El contacto del MPN también enviara una copia de los documentos al empleado cubierto. El empleado puede equipar cualesquiera expedientes médicos relevantes o material adicional al revisor medico independiente, con una copia al contacto del MPN según lo dispuesto en la sección 9768.11 (a) de 8 CCR. Si usted ha solicitado un examen en-persona y una forma especial de transporte que se requiere por su condición médica, el contacto del MPN se lo organizará. El contacto del MPN proporcionará el transporte y organizará un intérprete, si es necesario, con anticipo del examen en-persona. Todos gastos razonables del transporte serán incurridos por la compañía de seguros o el empleador conforme a sección 4600 del Código Laboral. Con la excepción del examen en-persona, el médico crítico independiente no tendrá contacto ex parte con ningún partido. Con la excepción de los asuntos que tratan con la programación de la cita, la programación de pruebas médicas y para obtener los registros médicos, toda comunicación entre el médico crítico independiente y todo partido será hecho en escrito notificando con copias ha todos partidos.

The IMR may order any diagnostic tests necessary to make their determination regarding medical treatment or diagnostic services for the injury or illness but shall not request you to submit to an unnecessary exam or procedure. If a test duplicates a test already given, the IMR shall provide justification for the duplicative test in their report. If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

The IMR will serve the report on the Administrative Director, the MPN Contact, you, your attorney, if any, within twenty days after the in-person examination or completion of the records review.

If the disputed health care service has not been provided and the IMR certifies in writing that an imminent and serious threat to the health of you exists, including, but not limited to, the potential loss of life, limb, or bodily function, or the immediate and serious deterioration of you, the report shall be expedited and rendered within three business days of the in-person examination by the IMR.

Subject to approval by the Administrative Director, reviews not covered above, may be extended for up to three business days in extraordinary circumstances or for good cause. Extensions for good cause shall be granted for; medical emergencies of the IMR or the IMR's family; death in the IMR's family; or natural disasters or other community catastrophes that interrupt the operation of the IMR's office operations.

Utilizing the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and taking into account any reports and information provided, the IMR shall determine whether the disputed health care service is consistent with the recommended standards. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

The IMR should not treat or offer to provide medical treatment for this injury or illness for which they have done an independent medical review evaluation for you unless a medical emergency arises during the in-person examination.

Neither you nor the employer not the insurer shall have any liability for payment for the independent medical review which was not completed within the required timeframes unless you and the employer each waive the right to a new independent medical review and elect to accept the original evaluation.

The Administrative Director shall immediately adopt the determination of the independent medical reviewer and issue a written decision within five business days of receipt of the report.

The parties may appeal the Administrative Director's written decision by filing a petition with the Workers' Compensation Appeals Board and serving a copy on the administrative Director, within twenty days after receipt of the decision.

If the IMR agrees with the diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall continue to receive treatment with physicians within the MPN.

If the IMR does not agree with the disputed diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall seek medical treatment with a physician of your choice either within or outside the MPN. If you choose to receive medical treatment with a physician outside the MPN, the treatment is limited to the treatment recommended by the IMR or the diagnostic service recommended by the IMR. The medical treatment shall be consistent with the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based. The employer or insurer shall be liable for the cost of any approved medical treatment in accordance with Labor Code section 5307.1 or 5307.11.

Si el IMR requiere pruebas adicionales, el IMR notificará ha el contacto del MPN dentro de una día de trabajo de la cita. Toda prueba será consecuente con el anexo médico de la utilización del tratamiento adoptado conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, las directriz de ACOEM, y para todas heridas no cubiertas por el anexo médico de la utilización del tratamiento o las directriz de ACOEM, de acuerdo con otra evidencia directriz médicas basadas de tratamiento generalmente reconocido por la comunidad médica nacional y basada científicamente.

El IMR puede ordenar alguna prueba diagnóstica necesaria para hacer su determinación con respecto al tratamiento médico o servicios diagnósticos para la herida o la enfermedad pero no le solicitará para someterse a un examen o procedimiento innecesario. Si una prueba duplica una prueba que ya se haya dado, el IMR proporcionará la justificación para la prueba duplicada en su informe.

Si usted falla de asistir ha un examen con el IMR y falla en hacer otra cita dentro de cinco días hábiles después de la cita que fallo, el IMR llevará acabo una revisión de los registros y hará una determinación basada en esos registros.

El IMR rendirá el informe al Director Administrativo, al contacto del MPN, ha usted, su abogado, si es que lo tiene, dentro de veinte días después del examen en-persona o revisión de los registros.

Si el servicio de asistencia medica disputada no se ha proporcionado y el IMR certifica en escrito que una amenaza inminente y grave a la salud de usted existe, incluyendo, pero no limitado a, la pérdida potencial de la vida, un miembro, o funciones fisiológicas, o el empeoramiento inmediato y grave de usted, el informe se facilitará y será rendido dentro de tres días hábiles del examen en-persona por el IMR.

Sujeto a la aprobación por el Director Administrativo, las revisiones no citadas anteriormente, podrían ser extendidas hasta tres días hábiles en circunstancias extraordinarias o por buena causa. Las extensiones por la causa buena se otorgarán para; emergencia médicas del IMR o por la familia del IMR; la muerte en la familia del IMR; o los desastres naturales u otras catástrofes de la comunidad que interrumpen la operación de la oficina del IMR.

Utilizar el anexo médico de la utilización del tratamiento estableció conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, la directriz de ACOEM, y tomando en cuenta todos los informes y la información proporcionada, el IMR determinará si el servicio disputado de asistencia médica es consecuente con los estándares recomendados. Para heridas no cubiertas por el anexo médico de la utilización del tratamiento o por la directriz de ACOEM, el tratamiento rendido será de acuerdo con otras directriz basado en la evidencia médica de tratamientos que son reconocidas generalmente por la comunidad médica nacional y basada científicamente.

El IMR no debe tratar ni debe ofrecer proporcionar el tratamiento médico para esta herida o la enfermedad por la cual se ha hecho una evaluación médica independiente para usted al menos que una emergencia médica haya ocurrido durante el examen en-persona.

Ni usted, ni el empleado, ni la compañía de seguros tendrán ninguna responsabilidad para el pago de la revisión médica independiente que no se haya completado dentro de las agendas requeridas a menos que usted y el empleador renuncien al derecho de una nueva revisión médica independiente y elijan aceptar la evaluación original.

El Director Administrativo adoptará inmediatamente la determinación del crítico médico independiente y publicará una decisión en escrito dentro de cinco días hábiles después de recibir del informe.

Los partidos pueden apelar a la decisión del Director Administrativo sometiendo una petición con la Oficina de Apelación de Compensación al Trabajador (Workers' Compensation Appeals Board) y notificar con una copia al Director administrativo, dentro de veinte días después del recibo de la decisión.

Si el IMR concuerda con el diagnóstico, el servicio diagnóstico o el tratamiento médico prescrito por el médico de tratamiento, usted continuará a recibir el tratamiento con médicos dentro del MPN.

Si el IMR no concuerda con el diagnóstico disputado, el servicio diagnóstico ni el tratamiento médico prescrito por el médico de tratamiento, usted tendrá la oportunidad de buscar el tratamiento médico con un médico de su selecto sea dentro de o fuera del MPN. Si usted elige recibir el tratamiento médico con un médico fuera del MPN, el tratamiento es limitado al tratamiento recomendado por el IMR o el servicio diagnóstico recomendado por el IMR. El tratamiento médico será consecuente con el anexo médico de la utilización del tratamiento establecido conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, las directriz de ACOEM. Para heridas no cubiertas por el anexo médico de la utilización del tratamiento ni por las directriz de ACOEM, el tratamiento rendido será de acuerdo con otras directriz médicas basadas en evidencia del tratamiento que son reconocidas generalmente por la comunidad médica nacional y basadas científicamente.

El empleador o la compañía de seguros serán responsables del costo de algún tratamiento aprobado de acuerdo con sección 5307.1 o 5307.11 del Código Laboral.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____
(name of doctor)(M.D., D.O., or medical group)

_____(street address, city, state, ZIP)

_____(telephone number)

Employee Name (please print):_____

Employee's Address:_____

Employee's Signature_____Date:_____

Physician: I agree to this Pre-designation:

Signature:_____Date:_____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 March 1, 2007)

PREDESIGNACION DE MEDICO PERSONAL

En caso usted sostiene una lesion o enfermedad relacionaron a su empleo,usted puede ser tratado para tal lesión o enfermedad por su médico personal (M.D.), medico de osteopática (D.O.) o el grupo médico si:

- su empleador ofrece cobertura del grupo de salud;
- el médico es su médico regular, que será un médico que ha limitado su ejercicio de la medicina a la práctica general o que es certificado o elegible internista, pediatra, el obstetra-ginecólogo, o practicante familiar, y ha dirigido anteriormente su tratamiento médico, y retiene sus registro medico;
- su "médico personal" puede ser un grupo médico si es una corporación o una asociación que se compone de médicos con licencia de medicina o de osteopatía, que opera una especialidad multiple integrada a un grupo médico que proporciona un extenso servicios médicos completos predominantemente para enfermedades de lesiones no de trabajo;
- antes de la lesion su médico estara de acuerdo en tratarle para lesiones de trabajo o enfermedades;
- antes de la lesión usted le proporcionara a su empleador el siguiente por escrito: (1) nota que usted desea a su médico personal tratarle para una lesion o enfermedad relacionado al trabajo, y (2) el nombre personal y dirección de su doctor.

Usted puede utilizar esta forma para notificar a su empleador si desea tener su médico personal o un médico de medicina osteopatico para tratarle a usted de una lesion o enfermedad relacionada a su trabajo y los requisitos antes mencionados son cumplidos.

AVISO DE PREDESIGNACION DE MEDICO PERSONAL

El empleado: Complete esta sección

Para: _____ (nombre de empleador) Si usted tiene una lesion o enfermedad escojo ser tratado por:

_____
(Nombre de médico) (M.D., D.O., o grupo médico)

_____(Dirección, ciudad, estado, zona postal)

_____(Número de teléfono)

Nombre del empleado (por favor escribir letra de molde):_____

Dirección del empleado:_____

Firma del Empleado:_____Fecha:_____

Médico: Estoy de acuerdo con esta predesignacion:

Firma :_____ Fecha :_____
(Médico o empleado designado del médico o grupo médico)

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado del médico o grupo médico no firma, otra documentación del acuerdo del médico para ser designado se requerirá de conformidad con el Título 8, Código de Regulaciones, sección 9780.1 (a) (3).

Título 8, Código de Regulaciones, sección 9783.
(Formulario DWC Facultativo 9783 01 de marzo 2007)

CORVEL

EMPLOYEE MPN INFORMATION

This information is being provided to you to explain your rights and responsibilities should you have an accident at work. You will also receive a copy of this notice at the time of injury.

- The California Workers' Compensation Regulation requires employees to utilize the Medical Provider Network (doctors, hospitals, ancillary services) who are part of a Medical Provider Network or MPN. The Medical Provider Network has been selected for treatment of **work related injuries.**

Employer Contact:
Contact Name: Jacob Seehoffer **Telephone Number: 800.966.5307**
Address: 600 City Parkway West
City, State, Zip: Orange, CA 92868

If you are injured on the job...

1. Report your injury to your supervisor/manager *immediately.*
   IN CASE OF EMERGENCY SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST EMERGENCY FACILITY.
2. You may be asked to provide information such as....
   - Your Name
   - Your Home Address, City, State, Zip, County, Telephone Number
   - Date of Birth
   - Social Security Number
   - Date, Time, Location and Nature of Injury
3. If you require medical treatment, A **Medical Provider Network physician** (or other health care provider) is available for you to see. The MPN network provider will become your primary care physician and will provide the necessary and appropriate treatment for your work related injury. Your primary care physician will direct your care overall and refer to specialists as required within the MPN. A **CorVel** nurse may be assigned to interact with you, your provider and employer. The MPN network, listing of the health care providers, is available from your employer MPN contact person, your claims adjuster, or online at www.corvel.com – under "Employees" heading, choose California from the drop down box. At any time you are choosing a physician, you have the right to select from the entire MPN.
4. If you are on Business-Related Travel or away from your work site when an injury occurs, call your supervisor/manager to report your injury immediately. They will help you in seeking medical attention. **In case of emergency seek immediate medical attention at the nearest emergency facility.**
5. If you are traveling, or now live outside the MPN geographical area, you will be supplied with at least three physicians within the access standards to choose from for your medical treatment. If there are not three MPN physicians within the access standards available to treat you, you may be allowed to use a non-MPN provider. You have the right to change physicians and obtain a 2nd or 3rd opinion from among the referred physicians.
6. Unless you pre-designated a personal physician you may only use physicians within the MPN. See exceptions in Transfer of Care and Continuity of Care policies.
7. If you are having trouble scheduling an appointment with a provider within the MPN, contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in getting an appointment scheduled for you.
8. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist.
9. Appointments for initial treatment will be available within 3 business days of your request. Non-emergency appointments with specialists will be available within 20 business days or receipt of referral.

ADDITIONAL INFORMATION REGARDING YOUR RIGHTS UNDER THE CALIFORNIA MPN.
You will be provided notification upon transfer into the MPN. You may go to a specialist outside the MPN if your primary treating MPN physician refers you to a specialist outside the network. You may also choose your own specialist from within the MPN network independent of any referral by your treating physician or provider.

CORVEL

INFORMACION DEL EMPLEADO SOBRE LA MPN

Se le brinda esta información para explicarle sus derechos y responsabilidades y lo que debe hacer si se accidenta en el trabajo. Usted también recibirá una copia de este aviso a la hora de lesión.

- La Regulación de Compensación Laboral de California requiere que empleados utilicen la Red de Proveedores Médicos (médicos, hospitales, servicios auxiliares) que son parte de una Red de Proveedores Médicos, sea, una MPN. La Red de Proveedores Médicos ha sido seleccionada para **tratamiento de lesiones ocasionadas en el trabajo**.

Contacto del Empleador:
Nombre del Contacto: Jacob Seehoffer **Número de Teléfono: 800.966.5307**
Dirección: 600 City Parkway West
Ciudad, Estado, Código Postal: Orange, CA 92868

Si usted se lesiona en el trabajo...

1. Reporte *inmediatamente* su lesión a su supervisor/gerente.
   EN CASO DE EMERGENCIA, BUSQUE ATENCION MEDICA INMEDIATA EN EL MÁS CERCANO CENTRO DE EMERGENCIA.
2. Le pueden pedir información tal como....
   - Su Nombre
   - Su Dirección, Ciudad, Estado, Código Postal, Condado, Número de Teléfono
   - Fecha de Nacimiento
   - Número de Seguro Social
   - Fecha, Hora, Lugar y Naturaleza de la Lesión
3. Si usted requiere tratamiento medico, un **médico de la Red de Proveedores Médicos** (u otro proveedor de cuidado médico) está disponible para atenderlo. El proveedor de la red MPN se hará su médico de cabecera y le brindará el tratamiento necesario y apropiado para su lesión ocasionada en el trabajo. Su médico de cabecera se encargará de su cuidado completo y hará referencias a especialistas como se requiera dentro del MPN. Una enfermera CorVel puede ser asignada para comunicarse con usted, su proveedor y empleador. Una lista de proveedores de servicios médicos de la red MPN está disponible de la persona contacto de la MPN de su empleador, de su ajustador de reclamos, o en línea en www.corvel.com - bajo el titulo "Empleados" escoja California de la caja ascendente. En cualquier momento cuando usted está eligiendo un medico, usted tiene el derecho de seleccionar del MPN entero.
4. Si usted se encuentra en un Viaje Relacionado al Trabajo o está fuera de su lugar de trabajo cuando ocurre una lesión, llame inmediatamente a su supervisor/ gerente para reportar su lesión. Ellos lo ayudarán a buscar atención médica. **En caso de emergencia, busque atención médica inmediata en el centro de emergencia más cercano.**
5. Si usted viaja o vive fuera de la área geográfica del MPN, usted será proporcionado por lo menos tres médicos para elegir su tratamiento médico dentro del reglamento que escoja de su tratamiento médico. Si en caso no hay tres medico del MPN dentro del reglamento disponible para tratarlo a usted, usted ce le permitirá a usar un proveedor accesible que no es de MPN. Usted tiene el derecho de cambiar médicos y obtener una segunda o tercer opinión dentro de los médicos recomendados.
6. A menos que usted pre-designado un médico personal que usted sólo puede utilizar a médicos dentro del MPN. Vea las excepciones en la Transferencia de Cuidado y Continuidad de Cuidado.
7. Si usted tiene problemas en programar una cita con un proveedor dentro de la MPN, comuníquese con el contacto de la MPN de su empleador, ajustador de reclamos, o gerente de casos, si es asignado, para que asistencia en programar una cita.
8. Si usted requiere referencia a un especialista (ortopédico, dermatólogo, etc.), comuníquese con el contacto de la MPN de su empleador, ajustador de reclamos, o su gerente de casos, si es asignado, para que le ayuden a seleccionar y programar una cita con un especialista.
9. Citas para tratamiento inicial serán disponibles dentro de 3 días hábiles de su solicitud. Citas con especialistas sin emergencia serán disponibles dentro de 20 días hábiles o al recibir la referencia.

INFORMACIÓN ADICIONAL CON RESPECTO A LAS SUS DERECHAS DEBAJO DE LA CALIFORNIA MPN.
Usted será notificación proporcionada sobre transferencia en el MPN. Usted puede ir a un especialista fuera del MPN si su médico primario del MPN que trata le refiere a un especialista fuera de la red. Usted puede también elegir a su propio especialista dentro de la independiente de la red del MPN de cualquier remisión por su médico o abastecedor que trata.

CORVEL

EMPLOYEE REQUEST FOR A SECOND/THIRD MEDICAL OPINION

You have the opportunity to request and obtain a second and a third medical opinion within the provider network if you have a disagreement with the treatment or diagnosis. During this process, you must continue to receive your treatment with your current treating physician, or another provider of your choice within the MPN. To view the entire list of MPN providers, you may log onto www.corvel.com as described in page 1, number 3. This process is as follows:

1. If you disagree with the treatment plan or diagnosis you can request a 2nd or 3rd medical opinion.
2. A request is generated from the employee either by phone or in writing to the Claims Adjuster.
3. The request is received by the Claims Adjuster who will provide a regional area listing of providers within the network for you to choose from. At any time you have the right to choose a physician from the entire MPN network or from the list provided.
4. You must schedule an appointment with one of the physicians from the supplied list or from the entire MPN within (60) sixty days, or it shall be deemed that you have waived your right to the second opinion process with regard to this disputed diagnosis or treatment. At any time you are choosing a physician, you have the right to select from the entire MPN.
5. Once you have obtained an appointment, you must notify your claims adjuster of the physician, the appointment date and time.
6. If the appointment is not made within 60 days of receipt of the list of available MPN providers, then you shall be deemed to have waived the second and/or third opinion process.
7. During this process, you are required to continue your treatment with the treating physician or a physician of your choice within the MPN.
8. If the 2nd or 3rd opinion physician determines that your injury is outside the scope of their practice, you will be provided with a new list of MPN providers and/or specialists.
9. If you disagree with the 2nd opinion, then you can request a 3rd opinion and follow Steps 2-5 as above.
10. If you disagree with the diagnosis or treatment of the third opinion physician, you may request an Independent Medical Review. At the time you request a third opinion, your employer, MPN contact or adjuster will give you information on requesting an Independent Medical Review and the form.
11. At the time of your selection of your third opinion physician, you will be supplied with information on how to request an independent medical review, along with an application for Independent Medical Review for you to complete, should you disagree with the third opinion.
12. The claims adjuster will contact the treating physician, provide a copy of the medical records or send the necessary records to the second and/or third opinion physician prior to the appointment date. Upon your request, you can receive a copy of the medical records from your claims adjuster.
13. The second/third opinion physician will be notified in writing that he or she has been selected to provide a second/third opinion and the nature of the dispute with a copy to you.
14. A copy of the written report shall be provided to the employee, the person designated by the employer or insurer, and the treating physician within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.
15. You may obtain the recommended treatment within the MPN. If you choose you may obtain the recommended treatment by changing physicians to the second opinion physician, third opinion physician, or another MPN physician.

CHANGING YOUR PHYSICIAN

You are allowed to change to another provider if you would like to change providers for any other reason than listed above under Employee Request for a Second/Third Opinion. Your request may be directed to your Nurse case Manager or your Claims Adjuster. The provider must be within the Medical Provider Network. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist. The specialist you choose can be from the entire MPN.

SOLICITUD DEL EMPLEADO PARA UNA SEGUNDA/TERCERA OPINIÓN MÉDICA

Usted tiene la oportunidad de solicitar y obtener una segunda y una tercera opinión médica dentro de la red de proveedores si usted no está de acuerdo con el tratamiento o diagnóstico. Durante este proceso, usted debe seguir recibiendo su tratamiento de su médico tratante actual, u otro proveedor que usted escoja dentro de la MPN. Para ver la lista entera de los proveedores, usted puede ir a www.corvel.com como se describe en pagina 1, numero 3.
Este proceso es así:

1. Si usted no está de acuerdo con el plan de tratamiento o el diagnóstico, puede solicitar una segunda o tercera opinión médica.
2. Una solicitud es creada del empleado por teléfono o por escrito al Ajustador de Reclamos.
3. La solicitud es recibida por el Ajustador de Reclamos que proveerá una lista regional de área de los mismos proveedores dentro de la red que están disponibles para su selección. En cualquier momento, usted tiene el derecho de escoger a un médico de la red entera de MPN o de la lista proporcionada.
4. Usted debe programar una cita con uno de los médicos de la lista brindada o de la lista MPN dentro de (60) sesenta días, se considerará que usted ha renunciado su derecho al proceso de segunda opinión con relación al diagnóstico o tratamiento disputado. En cualquier momento cuando usted está eligiendo un medico, usted tiene el derecho de seleccionar del MPN entero.
5. Una vez usted ha obtenido una cita, debe notificar al ajustador de reclamos sobre el médico, fecha y hora de la cita.
6. Si la cita no esta hecha dentro de 60 días de recibir la lista de proveedores disponibles del MPN, entonces usted se le considera deber renunciado al proceso de la segunda y o tercer opinión.
7. Durante este proceso, usted esta requerido ha continuar su tratamiento con el médico de trata o el médico de su elección dentro del MPN.
8. Si los médicos de la segunda o tercer opiniones determinan que su lesión esta fuera del alcance de practica, se le proveerá una lista nueva de proveedores del MPN y o especialistas.
9. Si usted no está de acuerdo con la segunda opinión, puede solicitar una tercera opinión, siguiendo los Pasos 2 – 5 antedichos.
10. Si usted no está de acuerdo con el diagnóstico o tratamiento del médico de la tercera opinión, puede solicitar una Revisión Médica Independiente. A la vez de solicitar la tercer opinión, su empleador, el contacto del MPN o su ajustador le dará la información de como solicitar la Revisión Medica Independiente y la forma de solicitud.
11. A la vez de su selección de su medico de tercer opinión, se le proporcionara con información de como solicitar una revisión medica independiente, con la solicitud para una Revisión Medica Independiente para que usted llene, si es que usted no esta de acuerdo con la tercer opinión.
12. El ajustador de reclamos contactará al médico que trata, proporcionarle una copia de los registros médicos o enviará los registros necesarios al segundo y/o tercer médico de la opinión antes de la fecha de nombramiento. Sobre su pedido, usted puede recibir una copia de los registros médicos por medio de su ajustador de reclamación.
13. El segundo/tercer médico de la opinión será notificado por escrito que él o ella han sido escogidos para proporcionar una segundo/tercer opinión y la razón de la disputa con una copia a usted.
14. Una copia del informe escrito será proporcionado al empleado, la persona designada por el empleador o el asegurador, y al médico que trata dentro de 20 días de la fecha del nombramiento o al recibir los resultados de las pruebas diagnósticas, el que es más tarde.
15. Usted puede obtener el tratamiento aconsejado dentro del MPN. Si usted le elige puede obtener el tratamiento aconsejado cambiando a médicos al segundo médico de la opinión, a tercer médico de la opinión, o a otro médico de MPN.

CAMBIANDO A SU MÉDICO

A le se permite cambiar a otro abastecedor si usted quisiera cambiar los abastecedores por cualquier otra razón que enumerada arriba bajo petición del empleado para una segunda/tercero opinión. Su petición se puede dirigir a su encargado del caso de la enfermera o a su ajustador de demandas. El abastecedor debe estar dentro de la red médica del abastecedor. Si usted requiere una remisión a un especialista, (ortopedista, dermatologist, etc.), entre en contacto con a su contacto del MPN del patrón, al ajustador de demandas, o a su encargado del caso, si está asignado, para la ayuda en seleccionar y programar una cita con un especialista. El especialista que usted elige puede ser del MPN entero.

TRANSFER OF ONGOING CARE INTO MPN

If you are being treated for an occupational injury or illness by a physician or provider prior to your enrollment into your employer's medical provider network (MPN), and your physician or provider becomes a provider or already is an MPN provider, the MPN/employer will notify you that your treatment is being provided by your physician or provider under the provisions of the MPN. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the MPN coverage effective date.

A dispute resolution policy is included in the Transfer of Ongoing Care policy. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN.

ACCESS STANDARDS

You have a right to access to MPN providers that are located within reasonable distances of your residence or workplace. The MPN must have a primary care physician and a hospital for emergency care within 30 minutes or 15 miles of your residence or workplace and providers of occupational health services and specialists within 60 minutes or 30 miles of your residence or workplace. If at any time you reside or work in a portion of the service area in which health care facilities are located outside the MPN access standards, the employer or MPN treating physician will assist the you in identifying a minimum of three (3) non-MPN providers in the specialty needed and within the access standard distance." If there are not three (3) providers in the needed specialty within the access standard distance you may choose a non-MPN provider.

CONTINUITY OF CARE

If you are treating in a medical provider network and the provider is terminated from participation in the MPN network, you have certain rights to continue your treatment with this terminated provider subject to the conditions set forth in your employer's Continuity of Care policy. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

A dispute resolution policy is included in the Continuity of Care policy. You may request a complete copy of the Continuity of Care policy from your employer or MPN.

LA TRANSFERENCIA DEL CUIDADO EN CURSO EN EL MPN

Si a un médico le está tratando para lesión o una enfermedad ocupacional o un abastecedor antes de su inscripción en la red médica del abastecedor de su patrón (MPN), y su médico o abastecedor se convierte en abastecedor o es ya abastecedor del MPN, el MPN/employer le notificará que su tratamiento está siendo proporcionado por su médico o abastecedor bajo provisiones del MPN. Usted puede solicitar una copia completa de la transferencia de la política en curso del cuidado de su patrón o MPN. Algunas circunstancias que pueden permitir el tratamiento continuado con el abastecedor terminado incluyen una condición aguda, una condición crónica seria, una enfermedad terminal, o funcionamiento de la cirugía o del otro procedimiento que es autorizado por el asegurador o el patrón como parte de un curso del tratamiento documentado y ha sido recomendado y documentado por el abastecedor para ocurrir en el plazo de 180 días de la fecha eficaz de la cobertura del MPN.

Una política de la resolución del conflicto se incluye en la transferencia de la política en curso del cuidado. Usted puede solicitar una copia completa de la transferencia de la política en curso del cuidado de su patrón o MPN.

LOS ESTÁNDARES DEL ACCESO

Usted tiene una derecha de tener acceso a los abastecedores del MPN que están situados dentro de distancias razonables de su residencia o lugar de trabajo. El MPN debe tener un médico primario del cuidado y un hospital para el cuidado de la emergencia en el plazo de 30 minutos o 15 millas de su residencia o lugar de trabajo y abastecedores de los servicios de la medicina del trabajo y especialistas a 60 minutos o a 30 millas de su residencia o lugar de trabajo. Si usted reside o trabaja en cualquier momento en una porción del área de servicio en la cual las instalaciones del cuidado médico están situadas fuera de los estándares del acceso del MPN, el patrón o el MPN que trata a médico le asistirá en identificar a un mínimo de tres (abastecedores 3) no-MPN en la especialidad necesitada y dentro de la distancia del estándar del acceso." Si no hay tres (3) abastecedores en la especialidad necesaria dentro de la distancia estándar del acceso usted puede elegir un abastecedor no-MPN.

CONTINUIDAD DEL CUIDADO

Si usted está tratando en una red médica del abastecedor y el abastecedor se termina de la participación en la red del MPN, usted tiene ciertas derechas de continuar su tratamiento con este abastecedor terminado conforme a las condiciones dispuestas en la continuidad de su patrón de la política del cuidado. Algunas circunstancias que pueden permitir el tratamiento continuado con el abastecedor terminado incluyen una condición aguda, una condición crónica seria, una enfermedad terminal, o funcionamiento de la cirugía o del otro procedimiento que es autorizado por el asegurador o el patrón como parte de un curso del tratamiento documentado y ha sido recomendado y documentado por el abastecedor para ocurrir en el plazo de 180 días de la fecha de la terminación del contrato.

Una política de la resolución del conflicto se incluye en la continuidad de la política del cuidado. Usted puede solicitar una copia completa de la continuidad de la política del cuidado de su patrón o MPN.

EMPLOYEE ACKNOWLEDGEMENT OF THE

MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, we have instituted a Medical Provider Network for Workers' Compensation.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your employer or claims adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through my employer.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name _____ Date _____

Employee Signature _____ Employer _____

Employee Number _____

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

RECONOCIMIENTO DEL EMPLEADO DE LA MEDICAL PROVIDER NETWORK

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta _____ Fecha _____

Firma del Empleado _____ Empleador _____

Número del Empleado _____

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

CORVEL

EMPLOYEE INFORMATION ON THE INDEPENDENT MEDICAL REVIEW PROCESS

This notice is to inform you of your rights, responsibilities and process in obtaining an Independent Medical Review (IMR). If you disagree with your treatment plan or diagnosis that the third opinion physician rendered, you have the right to request an Independent Medical Review. At the time you request a physician for a third opinion, your MPN contact or Claims Adjuster will provide you with this form covering the Independent Medical Review process. You will also be provided with an "Application for Independent Medical Review" form. The MPN contact or Claims Adjuster will fill out the "MPN Contact section" for you. You will need to complete the "employee section" of the form, indicate on the form whether you are requesting an in-person examination or a records review. You may also list an alternative specialty, if any, that is different from the specialty of the treating physician.

The Administrative Director will select an IMR with an appropriate specialty within 10 business days of receiving your Application for Independent Medical Review form. The Administrative Director's selection of the IMR will be based on the specialty of your treating physician, the alternative specialties listed by you and the MPN contact, and the information submitted with the Application for Independent Medical Review.

If you request an in-person examination, the Administrative Director will randomly select a physician from a list of available independent medical reviewers, with an appropriate specialty, who has an office located within thirty miles of your residential address, to be your independent medical reviewer. If there is only one physician with an appropriate specialty within thirty miles of your residential address, that physician shall be selected to the independent medical reviewer. If there are no physicians with an appropriate specialty who have offices located within thirty miles of your residential address, the Administrative Director will search in increasing file mile increments, until one physician is located. If there are no available physicians with this appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

If you request a record review, then the Administrative Director will randomly select a physician with an appropriate specialty from the list of available independent medical reviewers to be the IMR. If there are no physicians with an appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

The Administrative Director will send written notification of the name and contact information of the IMR to you, your attorney, if any, the MPN contact and the IMR. The Administrative Director will send a copy of the completed Application for Independent Medical Review to the IMR.

You, the MPN Contact, or the selected IMR can object within 10 calendar days of receipt of the name of the IMR to the selection if there is a conflict of interest as defined by section 9768.2. If the IMR determines that they do not practice the appropriate specialty, the IMR shall withdraw within 10 calendar days of receipt of the notification of selection. If the conflict is verified or the IMR withdraws, the Administrative Director will select another IMR from the same specialty. If there are no available physicians with the same specialty, the Administrative Director may select an IMR with another specialty based on the information submitted and in accordance with the procedure set forth for an in-person examination and for a records review.

If you request an in-person examination, within sixty calendar days of receiving the name of the IMR, you must contact the IMR to arrange an appointment. If you fail to contact the IMR for an appointment with sixty calendar days of receiving the name of the IMR, then you will be deemed to have waived the IMR process with regard to this disputed diagnosis or treatment of this treating physician. The IMR shall schedule an appointment with you within thirty calendar days of the request for an appointment, unless all parties agree to a later date. The IMR shall notify the MPN contact of the appointment date.

Should you decide to withdraw the request for an independent medical review, you need to provide written notice to the Administrative Director and the MPN contact.

During this process, the employee shall remain within the MPN for treatment pursuant to section 9767.6.

The MPN Contact shall send all relevant medical records to the IMR. The MPN Contact shall also send a copy of the documents to the covered employee. The employee may furnish any relevant medical records or additional materials to the Independent Medical Reviewer, with a copy to the MPN contact as set forth in 8 CCR Section 9768.11(a). If you have requested an in-person examination and a special form of transportation is required because of your medical condition, the MPN contact will arrange it for you. The MPN Contact shall furnish transportation and arrange for an interpreter, if necessary, in advance of the in-person examination. All reasonable expenses of transportation shall be incurred by the insurer or employer pursuant to Labor Code section 4600. Except for the in-person examination itself, the independent medical reviewer shall have no ex parte contact with any party. Except for matters dealing with scheduling appointments, scheduling medical tests and obtaining medical records, all communications between the independent medical reviewer and any party shall be in writing with copies served on all parties.

If the IMR requires further tests, the IMR shall notify the MPN Contact within one working day of the appointment. All tests shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and for all injuries not covered by the medical treatment utilization schedule or the ACOEM guidelines, in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

INFORMACIÓN DEL EMPLEADO SOBRE EL PROCESO DE LA REVISIÓN MÉDICA INDEPENDIENTE

Este aviso es para informarle de sus derechos, responsabilidades y el procedimiento a obtener una Revisión Medica Independiente o Independent Medical Review (IMR). Si usted no esta de acuerdo con su plan de tratamiento o el diagnóstico que el tercer médico de opinión rindió, usted tiene el derecho de solicitar una Revisión Medica Independiente o Independent Medical Review (IMR). Cuando usted solicite a un médico para una tercera opinión, su contacto del MPN o ajustadora de reclamos le proporcionará con esta forma que cubre el procedimiento de Una Revisión Medica Independiente o Independent Medical Review (IMR). Usted será proporcionado también con una forma "Solicitud para Una Revisión Medica Independiente o Independent Medical Review (IMR)". El contacto de MPN o Ajustadora de reclamos le llenará "la sección de MPN Contact". Usted necesitará completar "la sección de empleado" de la forma, indique en la forma si usted solicita un examen en-persona o una revisión de registros. Usted puede listar también una especialidad alternativa, si es distinta de la especialidad del médico de tratamiento.

El Director Administrativo (Administrative Director) escogerá un IMR con una especialidad apropiada dentro de 10 días hábiles de recibir la forma de solicitud para una Revisión Medica Independiente o Independent Medical Review (IMR). La selección del Director Administrativo sobre el IMR se basará en la especialidad de su médico de tratamiento, las especialidades alternativas en la lista escogidos por usted y por el contacto de MPN, y la información sometida con la Solicitud para obtener una Revisión Medica Independiente o Independent Medical Review (IMR).

Si usted solicita un examen en-persona, el Director Administrativo escogerá al azar un médico de una lista de médicos crítico s independientes y disponibles, con una especialidad apropiada, que tenga una oficina localizada dentro de treinta millas de su dirección residencial, para ser su médico crítico independiente. Si hay sólo un médico con una especialidad apropiada dentro de treinta millas de su dirección residencial, ese médico será escogido a ser el medico crítico independiente. Si no hay médicos con una especialidad apropiada que tenga las oficinas localizadas dentro de treinta millas de su dirección residencial, el Director Administrativo aumentará el incremento de milla de archivo, hasta que un médico sea localizado. Si no hay médicos disponibles con esta especialidad apropiada, el Director Administrativo puede elegir otra especialidad basada en la información sometida.

Si usted solicita una revisión del registro, entonces el Director Administrativo al azar escogerá un médico con una especialidad apropiada de la lista de médicos crítico s independientes y disponibles para ser el IMR. Si no hay médicos con una especialidad apropiada, el Director Administrativo puede elegir otra especialidad basada en la información sometida.

El Director Administrativo le enviará notificación en escrito del nombre de y la información de contacto del IMR ha usted, su abogado, si es que lo tiene, al contacto de MPN y al IMR. El Director Administrativo enviará una copia de la solicitud terminada para obtener una Revisión Medica Independiente o Independent Medical Review (IMR).

Usted, el contacto del MPN, o el IMR escogido pueden oponerse a la selección dentro de 10 días de calendario después de recibir del nombre del IMR, si hay un conflicto de intereses como definido por la sección 9768,2. Si el IMR determina que ellos no practican la especialidad apropiada, el IMR retirará la selección dentro de 10 días de calendario de recibir la notificación de la selección. Si el conflicto se verifica o el IMR se retira, el Director Administrativo escogerá otro IMR de la misma especialidad. Si no hay médicos disponibles con la misma especialidad, el Director Administrativo puede escoger un IMR con otra especialidad basada en la información sometida y de acuerdo con el conjunto de procedimiento establecido para un examen en-persona y para una revisión de registros.

Si usted solicita un examen en-persona, dentro de sesenta días de calendario después de recibir el nombre del IMR, usted debe contactar el IMR para hacer una cita. Si usted falla en contactar al IMR para hacer una cita dentro de sesenta días de calendario después de recibir el nombre del IMR, entonces será considerado de haber renunciado al procedimiento de IMR con respecto a este diagnóstico o el tratamiento disputado de su médico de tratamiento. El IMR fijará una cita con usted dentro de treinta días de calendario después del pedido de la cita, al menos de que todos los interesados concordarán a una fecha mas adelante. El IMR notificará el contacto de MPN de la fecha de la cita.

Si usted decide retirar el pedido para una revisión médica independiente, usted necesita proporcionar un aviso en escrito al Director Administrativo y al contacto del MPN.

Durante este proceso, el empleado permanecerá dentro del MPN para el tratamiento conforme a la sección 9767.6.

El contacto del MPN enviara todos los expedientes médicos relevantes al IMR. El contacto del MPN también enviara una copia de los documentos al empleado cubierto. El empleado puede equipar cualesquiera expedientes médicos relevantes o material adicional al revisor medico independiente, con una copia al contacto del MPN según lo dispuesto en la sección 9768.11 (a) de 8 CCR. Si usted ha solicitado un examen en-persona y una forma especial de transporte que se requiere por su condición médica, el contacto del MPN se lo organizará. El contacto del MPN proporcionará el transporte y organizará un intérprete, si es necesario, con anticipo del examen en-persona. Todos gastos razonables del transporte serán incurridos por la compañía de seguros o el empleador conforme a sección 4600 del Código Laboral. Con la excepción del examen en-persona, el médico crítico independiente no tendrá contacto ex parte con ningún partido. Con la excepción de los asuntos que tratan con la programación de la cita, la programación de pruebas médicas y para obtener los registros médicos, toda comunicación entre el médico crítico independiente y todo partido será hecho en escrito notificando con copias ha todos partidos.

The IMR may order any diagnostic tests necessary to make their determination regarding medical treatment or diagnostic services for the injury or illness but shall not request you to submit to an unnecessary exam or procedure. If a test duplicates a test already given, the IMR shall provide justification for the duplicative test in their report. If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

The IMR will serve the report on the Administrative Director, the MPN Contact, you, your attorney, if any, within twenty days after the in-person examination or completion of the records review.

If the disputed health care service has not been provided and the IMR certifies in writing that an imminent and serious threat to the health of you exists, including, but not limited to, the potential loss of life, limb, or bodily function, or the immediate and serious deterioration of you, the report shall be expedited and rendered within three business days of the in-person examination by the IMR.

Subject to approval by the Administrative Director, reviews not covered above, may be extended for up to three business days in extraordinary circumstances or for good cause. Extensions for good cause shall be granted for; medical emergencies of the IMR or the IMR's family; death in the IMR's family; or natural disasters or other community catastrophes that interrupt the operation of the IMR's office operations.

Utilizing the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and taking into account any reports and information provided, the IMR shall determine whether the disputed health care service is consistent with the recommended standards. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

The IMR should not treat or offer to provide medical treatment for this injury or illness for which they have done an independent medical review evaluation for you unless a medical emergency arises during the in-person examination.

Neither you nor the employer not the insurer shall have any liability for payment for the independent medical review which was not completed within the required timeframes unless you and the employer each waive the right to a new independent medical review and elect to accept the original evaluation.

The Administrative Director shall immediately adopt the determination of the independent medical reviewer and issue a written decision within five business days of receipt of the report.

The parties may appeal the Administrative Director's written decision by filing a petition with the Workers' Compensation Appeals Board and serving a copy on the administrative Director, within twenty days after receipt of the decision.

If the IMR agrees with the diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall continue to receive treatment with physicians within the MPN.

If the IMR does not agree with the disputed diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall seek medical treatment with a physician of your choice either within or outside the MPN. If you choose to receive medical treatment with a physician outside the MPN, the treatment is limited to the treatment recommended by the IMR or the diagnostic service recommended by the IMR. The medical treatment shall be consistent with the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based. The employer or insurer shall be liable for the cost of any approved medical treatment in accordance with Labor Code section 5307.1 or 5307.11.

Si el IMR requiere pruebas adicionales, el IMR notificará ha el contacto del MPN dentro de una día de trabajo de la cita. Toda prueba será consecuente con el anexo médico de la utilización del tratamiento adoptado conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, las directriz de ACOEM, y para todas heridas no cubiertas por el anexo médico de la utilización del tratamiento o las directriz de ACOEM, de acuerdo con otra evidencia directriz médicas basadas de tratamiento generalmente reconocido por la comunidad médica nacional y basada científicamente.

El IMR puede ordenar alguna prueba diagnóstica necesaria para hacer su determinación con respecto al tratamiento médico o servicios diagnósticos para la herida o la enfermedad pero no le solicitará para someterse a un examen o procedimiento innecesario. Si una prueba duplica una prueba que ya se haya dado, el IMR proporcionará la justificación para la prueba duplicada en su informe.

Si usted falla de asistir ha un examen con el IMR y falla en hacer otra cita dentro de cinco días hábiles después de la cita que fallo, el IMR llevará acabo una revisión de los registros y hará una determinación basada en esos registros.

El IMR rendirá el informe al Director Administrativo, al contacto del MPN, ha usted, su abogado, si es que lo tiene, dentro de veinte días después del examen en-persona o revisión de los registros.

Si el servicio de asistencia medica disputada no se ha proporcionado y el IMR certifica en escrito que una amenaza inminente y grave a la salud de usted existe, incluyendo, pero no limitado a, la pérdida potencial de la vida, un miembro, o funciones fisiológicas, o el empeoramiento inmediato y grave de usted, el informe se facilitará y será rendido dentro de tres días hábiles del examen en-persona por el IMR.

Sujeto a la aprobación por el Director Administrativo, las revisiones no citadas anteriormente, podrían ser extendidas hasta tres días hábiles en circunstancias extraordinarias o por buena causa. Las extensiones por la causa buena se otorgarán para; emergencia médicas del IMR o por la familia del IMR; la muerte en la familia del IMR; o los desastres naturales u otras catástrofes de la comunidad que interrumpen la operación de la oficina del IMR.

Utilizar el anexo médico de la utilización del tratamiento estableció conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, la directriz de ACOEM, y tomando en cuenta todos los informes y la información proporcionada, el IMR determinará si el servicio disputado de asistencia médica es consecuente con los estándares recomendados. Para heridas no cubiertas por el anexo médico de la utilización del tratamiento o por la directriz de ACOEM, el tratamiento rendido será de acuerdo con otras directriz basado en la evidencia médica de tratamientos que son reconocidas generalmente por la comunidad médica nacional y basada científicamente.

El IMR no debe tratar ni debe ofrecer proporcionar el tratamiento médico para esta herida o la enfermedad por la cual se ha hecho una evaluación médica independiente para usted al menos que una emergencia médica haya ocurrido durante el examen en-persona.

Ni usted, ni el empleado, ni la compañía de seguros tendrán ninguna responsabilidad para el pago de la revisión médica independiente que no se haya completado dentro de las agendas requeridas a menos que usted y el empleador renuncien al derecho de una nueva revisión médica independiente y elijan aceptar la evaluación original.

El Director Administrativo adoptará inmediatamente la determinación del crítico médico independiente y publicará una decisión en escrito dentro de cinco días hábiles después de recibir del informe.

Los partidos pueden apelar a la decisión del Director Administrativo sometiendo una petición con la Oficina de Apelación de Compensación al Trabajador (Workers' Compensation Appeals Board) y notificar con una copia al Director administrativo, dentro de veinte días después del recibo de la decisión.

Si el IMR concuerda con el diagnóstico, el servicio diagnóstico o el tratamiento médico prescrito por el médico de tratamiento, usted continuará a recibir el tratamiento con médicos dentro del MPN.

Si el IMR no concuerda con el diagnóstico disputado, el servicio diagnóstico ni el tratamiento médico prescrito por el médico de tratamiento, usted tendrá la oportunidad de buscar el tratamiento médico con un médico de su selecto sea dentro de o fuera del MPN. Si usted elige recibir el tratamiento médico con un médico fuera del MPN, el tratamiento es limitado al tratamiento recomendado por el IMR o el servicio diagnóstico recomendado por el IMR. El tratamiento médico será consecuente con el anexo médico de la utilización del tratamiento establecido conforme a sección 5307,27 del Código Laboral o, antes de la adopción de este anexo, las directriz de ACOEM. Para heridas no cubiertas por el anexo médico de la utilización del tratamiento ni por las directriz de ACOEM, el tratamiento rendido será de acuerdo con otras directriz médicas basadas en evidencia del tratamiento que son reconocidas generalmente por la comunidad médica nacional y basadas científicamente.

El empleador o la compañía de seguros serán responsables del costo de algún tratamiento aprobado de acuerdo con sección 5307.1 o 5307.11 del Código Laboral.

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____

(name of doctor)(M.D., D.O., or medical group)

_____(street address, city, state, ZIP)

_____(telephone number)

Employee Name (please print):_____

Employee's Address:_____

Employee's Signature_____Date:_____

Physician: I agree to this Pre-designation:

Signature:_____Date:_____

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 March 1, 2007)

PREDESIGNACION DE MEDICO PERSONAL

En caso usted sostiene una lesion o enfermedad relacionaron a su empleo,usted puede ser tratado para tal lesión o enfermedad por su médico personal (M.D.), medico de osteopática (D.O.) o el grupo médico si:

- su empleador ofrece cobertura del grupo de salud;
- el médico es su médico regular, que será un médico que ha limitado su ejercicio de la medicina a la práctica general o que es certificado o elegible internista, pediatra, el obstetra-ginecólogo, o practicante familiar, y ha dirigido anteriormente su tratamiento médico, y retiene sus registro medico;
- su "médico personal" puede ser un grupo médico si es una corporación o una asociación que se compone de médicos con licencia de medicina o de osteopatía, que opera una especialidad multiple integrada a un grupo médico que proporciona un extenso servicios médicos completos predominantemente para enfermedades de lesiones no de trabajo;
- antes de la lesion su médico estara de acuerdo en tratarle para lesiones de trabajo o enfermedades;
- antes de la lesión usted le proporcionara a su empleador el siguiente por escrito: (1) nota que usted desea a su médico personal tratarle para una lesion o enfermedad relacionado al trabajo, y (2) el nombre personal y dirección de su doctor.

Usted puede utilizar esta forma para notificar a su empleador si desea tener su médico personal o un médico de medicina osteopatico para tratarle a usted de una lesion o enfermedad relacionada a su trabajo y los requisitos antes mencionados son cumplidos.

AVISO DE PREDESIGNACION DE MEDICO PERSONAL

El empleado: Complete esta sección

Para: _____ (nombre de empleador) Si usted tiene una lesion o enfermedad escojo ser tratado por:

_____
(Nombre de médico) (M.D., D.O., o grupo médico)

_____(Dirección, ciudad, estado, zona postal)

_____(Número de teléfono)

Nombre del empleado (por favor escribir letra de molde):_____

Dirección del empleado:_____

Firma del Empleado:_____Fecha:_____

Médico: Estoy de acuerdo con esta predesignacion:

Firma :_____ Fecha :_____
(Médico o empleado designado del médico o grupo médico)

El médico no está obligado a firmar este formulario, sin embargo, si el médico o empleado designado del médico o grupo médico no firma, otra documentación del acuerdo del médico para ser designado se requerirá de conformidad con el Título 8, Código de Regulaciones, sección 9780.1 (a) (3).

Título 8, Código de Regulaciones, sección 9783.
(Formulario DWC Facultativo 9783 01 de marzo 2007)

CORVEL

NOTICE
THAT

Employer: PAMLAB INC.

has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: CHUBB INDEMNITY INSURANCE COMPANY

Policy Number: (13)7575-25-17

Address for the above insurance carrier is 1330 POST OAK BLVD STE 2400, HOUSTON, TX 77056-3031

Telephone number is (213)612-0880

WORKERS' COMPENSATION

IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported promptly.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION

IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM - CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD

"For your protection, Utah Law requires the following to appear on this form, any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION

160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610

(801)530-6800 – (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.

NOTICE

The undersigned employer hereby gives notice that the payment of compensation to employees and their dependents has been secured in accordance with the provisions of the Employer's Liability Insurance Law, Title 34, Chapter 15, Article 5, Revised Statutes New Jersey, by insuring with the

Chubb Indemnity Ins Co.
15 Mountain View Road
P.O. Box 1617
Warren, NJ 07059-1617

for the period

Beginning 08/19/12 **Ending** 08/19/13

Employer PAMLAB INC.

In accordance with the above cited law, notice of compliance must be posted and maintained conspicuously in and about the employer's workplaces.

Form 16NJ A

Form 08-10-0534 (Ed. 12-03)

State of Connecticut Workers' Compensation Commission

Notice to Employees

Workers' Compensation Act

Chapter 568 of the Connecticut General Statutes (the Workers' Compensation Act) requires your employer,

PAMLAB INC.

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states: "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of failure, provided the burden of proof with respect to such prejudice shall rest upon the employer." Such an injury report by the employee is NOT an official written notice of claim for workers' compensation benefits. (The Form 30C is necessary to satisfy this requirement.)

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name CHUBB INDEMNITY INSURANCE COMPANY

Address 2800 POST OAK BLVD STE 2400 **Telephone** (203)782-4000

City/Town HOUSTON **State** TX **Zip Code** 77056-3031

Approved Medical Care Plan ☐ **Yes** ☐ **No**

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address: _____ **Telephone** _____

City/Town _____ **State** _____ **Zip Code** _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company or the Workers' Compensation Commission (1-800-223-9675).

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted _____

MWCC – WORKERS COMPENSATION FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

SIC CODE | EMPLOYER FEIN

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE (M)
☐ FEMALE (F)
☐ UNKNOWN (U)

MARITAL STATUS
☐ UNMARRIED/SINGLE/DIVORCED (U)
☐ MARRIED (M)
☐ SEPARATED (S)
☐ UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

OF DEPENDENTS

NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:

DAYS WORKED WEEK

FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO

DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

NO MEDICAL TREATMENT	(0)	☐
MINOR: BY EMPLOYER	(1)	☐
MINOR CLINIC/HOSP	(2)	☐
EMERGENCY CARE	(3)	☐
HOSPITALIZED>24 HRS	(4)	☐
FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	(5)	☐

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

WORKERS' COMPENSATION – FIRST REPORT OF INJURY

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) – The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE – The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN – Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER – Carrier's claim or file number.

REPORT PURPOSE CODE – A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION – State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER – Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER – The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) – The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # – The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) – The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD – The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) – An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR – The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN – Carrier's Federal Employer Identification Number.

POLICY/SELF-INSURED NUMBER – The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN – Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER – The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST, MIDDLE) – Employee's legally recognized name.

ADDRESS – The mailing address used by the employee.

PHONE – A telephone number where the employee can be reached.

DATE OF BIRTH – The date the employee was born.

SOCIAL SECURITY NUMBER – A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED – The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE – State where employee was hired.

SEX – The code which indicates the sex of the employee.

MARITAL STATUS – The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE – This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS – Indicate the employee's work status. The valid choices are: Full-Time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE – A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the **NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE**.

RATE – The reported employee's wage rate at the time of injury.

 # DAYS WORKED/WEEK – The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY – State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE – State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK – The time employee began work on date of injury.

DATE OF INJURY/ILLNESS – The date employee was injured.

TIME OF OCCURRENCE – The time employee was injured.

LAST WORK DATE – The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED – The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN – The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER – Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS – Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED – Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES – Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE – The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE – The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – The county where the injury occurred. If the injury did not occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint. Enter "'NA" for not applicable if no equipment, materials, or chemicals were being used.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED – Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g., walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL – Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

CAUSE OF INJURY CODE – The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK – Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH – Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED – Check if applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) – The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) – The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT – Check applicable choices.

WITNESSES (NAME & PHONE #) – The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED – The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED – The date this report was prepared.

PREPARER'S NAME & TITLE – The name and title of the person who prepared this report.

PHONE NUMBER – The phone number of the person who prepared this report.

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100 Boston, MA 02114-2017

617-727-4900 - http: //www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

CHUBB INDEMNITY INSURANCE COMPANY
NAME OF INSURANCE COMPANY

2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118
ADDRESS OF INSURANCE COMPANY

(13)7575-25-17 — POLICY NUMBER

08/19/12 TO 08/19/13 — EFFECTIVE DATES

STONE INSURANCE, INC. — NAME OF INSURANCE AGENT

P.O. BOX 1710
MANDEVILLE
LA
70470 — ADDRESS

(985) 626-1255 — PHONE #

PAMLAB INC. — EMPLOYER

P.O. BOX 8950
MANDEVILLE
LA
70470 — ADDRESS

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY)

DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL — ADDRESS

TO BE POSTED BY EMPLOYER

STATE OF ALABAMA
WORKERS' COMPENSATION
INFORMATION

If you are injured on the job, or contract an occupational disease, notify your employer immediately.

Your employer will advise you of the physician to see for authorized medical treatment.

WORKERS' COMP INSURANCE CARRIER CHUBB INDEMNITY INSURANCE COMPANY

TELEPHONE NUMBER (713)297-4600

ASSISTANCE IS AVAILABLE UNDER THE ALABAMA WORKERS' COMPENSATION LAW INCLUDING MEDIATION SERVICE. FOR INFORMATION CALL:

1-800-528-5166
Department of Industrial Relations
Workers' Compensation Division
649 Monroe Street
Montgomery, AL 36131

CODE OF ALABAMA, 1975. § 25-5-290(d), REQUIRES THAT THIS NOTICE BE POSTED IN ONE OR MORE CONSPICUOUS PLACES IN YOUR BUSINESS.

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election to Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:

   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;

   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and

   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

1. **GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation , the PPP counts as one of your two choices of providers.
2. **NOTIFY YOUR EMPLOYER**. You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number , Social Security number, and a brief description of the injury or illness.
3. **LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

   If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

   It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.
4. **KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

   Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved the the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033	Chicago:	312/814-6611	Peoria:	309/671-3019	Springfield: 217/785-7087
Web site: www.iwcc.il.gov	Collinsville:	618/346-3450	Rockford:	815/987-7292	TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims	CHUBB INDEMNITY INSURANCE COMPANY		
Business address	2800 POST OAK BLVD SUITE 2400 HOUSTON, TX 77056-6118		
Business phone			
Effective date	08/19/12	Termination date	08/19/13
Policy number	(13)7575-25-17	Employer's FEIN	720509664

ICPN 10/11 Printed by the authority of the State of Illinois.
08 10 0365 (Rev. 10-11)

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

BUREAU OF WORKERS' COMPENSATION

REMEMBER:

It is Important to Tell Your Employer about Your Injury

The name, address and telephone number of your employer's workers' compensation insurance company, third-party administrator (TPA), or person handling workers' compensation claims for your company, are shown below.

Employer Name: PAMLAB INC. **Date Posted:** _____

IF INSURED:
(Complete all applicable spaces)

Name of Insurance Company:
CHUBB INDEMNITY INSURANCE COMPANY

Address: 2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Telephone Number: _____

Insurer's Bureau Code: _____

IF SOMEONE OTHER THAN INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number:

IF SELF-INSURED:
(Complete all applicable spaces)

Name of person handling claims at the self-insured:

Address:

Telephone Number:

Self-Insured Bureau Code:

IF SOMEONE OTHER THAN SELF-INSURER IS HANDLING CLAIMS:
(Complete all applicable spaces)

Name of TPA (Claims administrator):

Address:

Telephone Number:

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

08 10 0373 (Rev. 11-09)

Form AR – H	ARKANSAS WORKER'S COMPENSATION COMMISSION	
Authority, Ark. Code Ann. § 11-9-514 AWCC Rule 7, 33 Revised 1-1-2001	324 Spring Street • Little Rock, AR 72201 Mail: P.O. Box 950 • Little Rock, AR 72203-0950 501-682-3930 • 1-800-622-4472	**H**

HEALTH CARE NOTICE FOR EMPLOYEES UNDER MANAGED CARE

Your employer has contracted with the following Managed Care Organization (MCO):

Name CORVEL

Address 15301 DALLAS PARKWAY, STE 300, ADDISON, TX 75001

or has been certified as an Internal Managed Care System **(IMCS).** ***You are required to receive treatment through this MCO/IMCS if you receive a work-related injury. If you do not receive treatment through this MCO/IMCS, or you do not obtain permission to change treatment provider(s), then you may be required to pay for the treatment you receive***. Emergency treatment is exempt from this requirement.

Employees are covered under the MCO/IMCS ***after*** the employer posts Form H. Prior notice given to employees by a certified MCO shall fulfill the above notice requirements.

The telephone number of your employer's MCO/IMCS is (972) 383-1700. You may call this number if you have questions about managed care or if you need names of physicians.

If you are injured on the job, you should notify your supervisor immediately. Your supervisor will arrange for treatment or explain what you need to do to receive treatment for your injury.

If you have a problem with or a dispute about this MCO/ IMCS, you may file a complaint within thirty (30) days of the occurrence. To obtain information contact your supervisor, the MCO/ IMCS, or the Medical Cost Containment Division at the AW CC (1- 800- 622- 4472 or 501- 682- 3930).

If you are balance billed by a physician for a covered workers' compensation injury, you should notify your employer. Balance billing occurs when physicians are paid according to the MCO/ IMCS contract or the Arkansas W orkers' Compensation Fee Schedule, the amount they were paid is less than the amount of their bill, and they attempt to collect the difference from employees.

Choice/change of physician is controlled by law. Your employer may choose the initial treating physician. Any referral would be to parties abiding by MCO rules, terms, and conditions. Emergency medical treatment is exempted. If you want a change of physician, request it from the insurance carrier or employer. If the decision is unsatisfactory, you may petition the Commission for a change. "The injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission." Ark. Code Ann. § 11-9-508(e) ***Treatment or services furnished or prescribed other than according to the above, EXCEPT EMERGENCY TREATMENT, shall be at your own expense.***

TENNESSEE WORKERS' COMPENSATION INSURANCE

Employers: The law requires this notice to be conspicuously posted at the employer's place of business so all employees have access to it.

WHO IS REQUIRED TO HAVE WORKERS' COMPENSATION INSURANCE?

All employers with five (5) or more full or part-time employees.
All employers engaged in the mining and production of coal with one (1) or more employees.
All contractors in the construction industry with one (1) or more employees.

To confirm if an employer is subject to the workers' compensation law and if so to obtain the name of the workers' compensation insurance company contact:

_____
Name of employer representative authorized to provide information on workers' compensation

_____
Telephone number of employer representative to provide information on workers' compensation

_____
Address of employer representative to provide information on workers' compensation

WHAT SHOULD AN EMPLOYEE DO IF INJURED AT WORK?

1. Report the injury to the employer immediately. Employer notification is required.

and 2. Select a treating physician from a panel provided by the employer.

To report an injury contact:

_____
Name of employer representative to notify in event of a work related injury

_____
Telephone number of employer representative to notify in event of a work related injury

_____
Address of employer representative to notify in event of a work related injury

WHAT SHOULD AN EMPLOYER DO WHEN AN INJURY IS REPORTED?

1. Immediately complete a First Report of Work Injury form and send it to the workers' compensation insurance company or the third party administrator to be filed with the Tennessee Dept. of Labor and Workforce Development, Workers' Compensation Division.

and 2. Offer a panel of physicians.

The employer shall designate a group of three (3) or more physicians or surgeons not associated together in practice from which the injured employee shall have the privilege of selecting the operating surgeon or the attending physician. If the injury is a back injury, the panel shall be expanded to four (4), one of whom must be a doctor of chiropractic. If a doctor of chiropractic is chosen, chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The provisions for chiropractic care shall not apply to workers' compensation self insurer pools established pursuant to Section 50-6-405(a)(1). If the injury requires the treatment of physician or surgeon who practices orthopedic or neuroscience medicine then the employer may appoint a panel of physicians or surgeons practicing orthopedic or neuroscience medicine consisting of five (5) physicians, with no more than four (4) physicians affiliated in practice together. The employee may select a treating physician or surgeon from the employer panel.

The Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, has staff available to help both employees and employers. For more information contact:

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION
220 FRENCH LANDING DRIVE
NASHVILLE, TENNESSEE 37243-1002
615-532-4812 OR TOLL FREE 1-800-332-2667 OR 1-800-332-2257 (TDD)
www.tennessee.gov/labor-wfd/wcomp.html

LB-0922 (rev. 10-07)
08 10 0488 (Rev. 10-07)

WORKER'S COMPENSATION NOTICE

Your employer is required to provide for payment of benefits under the Worker's Compensation Act of the State of Indiana.

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The worker's compensation insurance carrier or the administrator for

PAMLAB INC. is: CHUBB INDEMNITY INSURANCE COMPANY

(name of company) (name of insurance carrier or administrator)

(name of carrier/administrator)

2800 POST OAK BLVD

(mailing address)

SUITE 2400

(city, state, zip)

HOUSTON, TX 77056-6118

(telephone number)

(contact person)

For more information about rights or procedures under the Indiana Worker's Compensation system, call or write:

Worker's Compensation Board of Indiana
Ombudsman Division
402 W. Washington St., Rm W196
Indianapolis, IN 46204
(317) 232-3808
1-800-824-2667

COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303.318.8700, or visit our website at: www.coworkforce.com/dwc/.

COLORADO DIVISION OF WORKERS' COMPENSATION
633 17TH Street, Suite 400, Denver, CO 80202-3660

DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION

P.O. BOX 56098 • WASHINGTON, DC 20011 • (202) 671-1000 • (202) 671-1929 (fax)

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.

2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.

3. You may not sue your employer as a result of a work-connected injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.

4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.

5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.

6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.

2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.

3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date or knowledge thereof.

4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.

5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.

6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.

7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations.

NAME OF INSURANCE COMPANY:

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

NAME OF EMPLOYER:

PAMLAB INC.

By _____

720509664

EMPLOYER I.D. NUMBER
(If number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1DCWC
08 10 0503 (Ed. 6-02)

STATE OF NEW YORK - WORKERS' COMPENSATION BOARD
ESTADO DE NUEVA YORK - JUNTA DE COMPENSACION OBRERA

NOTICE OF COMPLIANCE
TO EMPLOYEES
IMPORTANT INFORMATION FOR EMPLOYEES WHO ARE INJURED OR SUFFER AN OCCUPATIONAL DISEASE WHILE WORKING.

1. By posting this notice and information concerning your rights as an injured worker, your employer is in compliance with the Workers' Compensation Law.
2. If you do not notify your employer within 30 days of the date of your injury your claim may be disallowed, so do so immediately.
3. You are entitled to obtain any necessary medical treatment and should do so immediately.
4. You may choose any doctor, podiatrist, chiropractor or psychologist referred by a medical doctor that accepts NY State Workers' Compensation patients and is Board authorized. However, if your employer is involved in a certified preferred provider organization (PPO) you must first be treated by a provider chosen by your employer and your employer must give you a written statement of your rights concerning further medical care.
5. You should tell your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and with your employer's insurance company, which is indicated at the bottom of this form.
6. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work.
7. You should not pay any medical providers directly. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire a representative do not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. If you have difficulty in obtaining a claim form or need help in filling it out, or if you have any other questions or problems about a job-related injury, contact any office of the Workers' Compensation Board.

WORKERS' COMPENSATION BOARD OFFICES
Albany, 12241 - 100 Broadway-Menands - (866) 760-5157
***Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373**
Binghamton, 13901 - State Office Bldg. - 44 Hawley St. - (866) 802-3604
Buffalo, 14203 - 295 Main Street, Suite 400 - (866) 211-0645
***Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354**
***Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630**
***New York, 10027 - 215 W.125th St., Manhattan - (800) 877-1373**
***Peekskill, 10566 - 41 North Division St. (866) 746-0552**
***Queens, 11432 - 168-46 91st Ave., Jamaica (800) 877-1373**
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

*** DOWNSTATE MAILING ADDRESS**
Claims-related mail for the Hauppauge, Hempstead, Peekskill and all NYC offices should be mailed to: **PO Box 5205 Binghamton, NY 13902-5205** *Statewide Fax: 877-533-0337*

AVISO DE CUMPLIMIENTO
A EMPLEADOS
INFORMACION IMPORTANTE PARA EMPLEADOS QUE SEAN LESIONADOS O SUFRAN UNA ENFERMEDAD OCUPACIONAL MIENTRAS TRABAJAN.

1. Su patrono está cumpliendo la Ley de Compensación Obrera cuando despliega este comunicado concerniente a sus derechos como trabajador lesionado.
2. Si usted no notifica a su patrono dentro del término de 30 dias de haber sufrido su lesión su reclamación podría ser desestimada, por eso notifique inmediatamente.
3. Usted tiene derecho a recibir cualquier tratamiento médico necesario relacionado con su lesión y debe gestionarlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para c ualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en cualquiera de estos programas establecidos por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo.
7. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. Si tiene dificultad en conseguir un formulario de reclamación o necesita ayuda para llenarlo ó tiene dudas sobre cualquier situación relacionada con una lesión o enfermedad comuniquese con la oficina mas cercana de la Junta.

Robert E. Beloten

ROBERT E. BELOTEN, CHAIR/PRESIDENTE

Workers' Compensation benefits, when due, will be paid by (Los beneficios de Compensación Obrera, cuando debidos, seran pagados por):

Name, address and telephone number of licensed insurance carrier, authorized group self-insurer or main office of authorized self-insurer
CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

For Insurance Carriers ONLY: Policy No. (13)7575-25-17

Policy in Force from 08/19/12 *to* 08/19/13

Name of employer (Nombre del patrono)

PAMLAB INC.

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Failure by an employer to post this notice in and about the employer's place or places of business may result in a $250 penalty for each violation.

08 10 0504 (Rev. 1-11)
C-105 (1-11)
Workers' Compensation Board
Prescribed by Chairman
State New York
www.wcb.state.ny.us

MISSISSIPPI WORKERS' COMPENSATION

NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and maintains workers' compensation insurance coverage with the following:

CHUBB INDEMNITY INSURANCE COMPANY

2800 POST OAK BLVD

SUITE 2400

HOUSTON, TX 77056-6118

II. Individual workers' compensation claims will be submitted to and processed by:

Two Live Oak Center

3445 Peachtree Road, N.E. Suite 900

Atlanta, GA 30326-1276

III. This workers' compensation coverage is effective for the following period:

08/19/12 to 08/19/13 .

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

_____

(Name of employer contact person)

_____

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

Form 1A *Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees*

All employees of this employer who are entitled to benefits of the Workers' Compensation Code are hereby notified that this employer has complied with all rules of the Workers' Compensation Court and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Code. All employees are further notified this employer will furnish first aid, medical, diagonostic, surgical and any other like services required by law as well as payments of compensation to any injured employee as provided in the Workers' Compensation Code.

Any employee who has suffered a compensable injury covered by the Workers' Compensation Code shall be entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform the same occupational duties the employee was performing prior to the injury.

The Oklahoma Workers' Compensation Court has a counselor (ombudsman) program to provide information to injured workers, employers, and other interested parties.

Mediation is available to address certain workers' compensation disputes.

For information, call 405-522-8760 or In-State Toll Free 800-522-8210.

Signature of Employer

CHUBB INDEMNITY INSURANCE COMPANY

Insurer & Insurer Phone Number

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of injury, any claim for compensation may be forever barred.

If accidentally injured or affected by cumulative trauma or an occupational disease, the employee may file a claim for compensation with the Workers' Compensation Court. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Court. The forms are posted on the Court's web site, www.owcc.state.ok.us/court_forms.htm.

A claim for compensation must be filed with the Court within the time specified by law, or be forever barred. Based on law effective August 26, 2011, a claim for compensation for any accidental injury or death must be filed with the Court within two (2) years from the date of the accidental injury or death; a claim for compensation for occupational disease must be filed with two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred; and a claim for compensation for cumulative trauma must be filed within two (2) years of when the employee was last employed by the employer. Provided, claims may be filed within two (2) years from the date of the last medical treatment authorized by the employer or payment of any compensation or remuneration paid in lieu of compensation.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical, diagnostic, surgical and any other like services that are reasonable and necessary. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. If an employee is injured and this results in the loss of time beyond his/her shift, or requires medical attention away from the work site (fatal or otherwise), the employer MUST file a Form 2 with the Workers' Compensation Court within ten (10) days of the notice of injury. The employer must provide a copy of the Form 2 to the employer's workers' compensation insurance carrier, if any.

No agreement by any employee to pay any portion of premiums paid by the employer to maintain or carry compensation insurance as required by law shall be valid. Any employer who deducts money from the wages or salary of any employee for that purpose who is entitled to workers' compensation shall be guilty of a misdemeanor.

If the employer has actual notice of an undisputed injury and the employer's insurance carrier fails to commence weekly temporary total disability benefit payments due within the time provided by law, the insurer may be subject to a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tele. 405-522-8600 (OKC) • 918-581-2714 (TU) • In-State Toll Free 800-522-8210
Web Site • www.owcc.state.ok.us

This notice must be posted and maintained by the employer in one or more conspicuous places.

08 10 0519 (Rev. 8-11)

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

INFORMATION FOR INJURED EMPLOYEES

THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER MAY 15, 2011

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 30 calendar days from the date of accident or the date of injury by repetitive trauma; (B) 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, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 20 calendar days after the employee's last day of actual work for the employer.

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 manager.

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.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normaly due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 2/3 percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation Law provides for additional benefits.

DIVISION OF WORKERS COMPENSATION – OMBUDSMAN / CLAIMS ADVISORY UNIT
401 SW Topeka Blvd., Ste. 2, Topeka, KS 66603-3105 • Phone (785) 296-2996, (800) 332-0353 • Fax (785) 296-0025

K-WC 27 (Rev. 3-12)
08 10 0521 (Rev. 3-12)

KANSAS DEPARTMENT OF LABOR
Information for Injured Employees

RESPONSIBILITIES OF THE EMPLOYER

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company _____

Address _____

_____

Contact Person _____

Phone (_____) _____

Email _____

DIVISION OF WORKERS COMPENSATION – OMBUDSMAN / CLAIMS ADVISORY UNIT
401 SW Topeka Blvd., Ste. 2, Topeka, KS 66603-3105 • Phone (785) 296-2996, (800) 332-0353 • Fax (785) 296-0025

K-WC 27 (Rev. 3-12)
08 10 0521 (Rev. 3-12)

FORM 17

Revised 5/2010

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- Report the injury or occupational disease to the Employer immediately.
- Give written notice to the Employer within 30 days.
- File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.
- If a medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- Provide all necessary medical services to the Employee.
- Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $2,000.00.
- Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.
- Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or **safety@ic.nc.gov**

NORTH CAROLINA INDUSTRIAL COMMISSION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

08 10 0522 (Rev. 5-10)

COMMONWEALTH OF KENTUCKY
WORKERS COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name: PAMLAB INC.

Address: P.O. BOX 8950

MANDEVILLE LA 70470

Workers Compensation Carrier (or third party administrator): CHUBB INDEMNITY INSURANCE COMPANY

Policy #: (13)7575-25-17 , **effective** 08/19/12 **to** 08/19/13

Address: 233 South Wacker Drive, Suite 4700, Chicago, IL 60606-6303

Telephone: (312) 454-4200 **Contact Person** _____

EMPLOYEES: If INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved provider network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS ☐ **IS NOT** ☒ **participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is** _____ **; its representative is** _____ **, phone number** _____ .

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) days of disability. A CLAIM MUST BE filed with the Office of Workers Claims WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The KENTUCKY OFFICE OF WORKERS CLAIMS AT 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, covered and non-covered employers shall notify their employees of coverage status, in writing. This additional notice:

(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) shall be provided at the time the employer notifies the insurance carrier that the employer is dropping coverage if there will be a period during which the employees will not be covered;

(3) shall be provided at the time an employer obtains coverage, as necessary to allow the employee to elect to retain common law rights;

(4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3) for appropriate language); and

(5) if the employer is covered by workers' compensation insurance, or becomes covered, whether by commercial insurance or by becoming a certified self-insurer, shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

WORK EXPOSURE TO BODILY FLUIDS

NOTICE TO EMPLOYEES

Re: Human Immunodeficiency Virus (HIV),
Acquired Immune Deficiency Syndrome (AIDS) & Hepatitis C

Employees are notified that a claim may be made for a condition, infection, disease, or disability involving or related to the Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or Hepatitis C within the provisions of the Arizona Workers' Compensation Law, and the rules of The Industrial Commission of Arizona. Such a claim shall include the occurrence of a significant exposure at work, which generally means contact of an employee's ruptured or broken skin or mucous membrane with a person's blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. **AN EMPLOYEE MUST CONSULT A PHYSICIAN TO SUPPORT A CLAIM.** Claims cannot arise from sexual activity or illegal drug use.

Certain classes of employees may more easily establish a claim related to HIV, AIDS, or Hepatitis C if they meet the following requirements:

1. The employee's regular course of employment involves handling or exposure to blood, semen, vaginal fluid, surgical fluid(s) or any other fluid(s) containing blood. Included in this category are health care providers, forensic laboratory workers, fire fighters, law enforcement officers, emergency medical technicians, paramedics and correctional officers.

2. **NO LATER THAN TEN (10) CALENDAR DAYS** after a possible significant exposure which arises out of and in the course of employment, the employee reports in writing to the employer the details of the exposure as provided by Commission rules. Reporting forms are available at the office of this employer or from the Industrial Commission of Arizona, 800 W. Washington, Phoenix, Arizona 85007, (602) 542-4661 or 2675 E. Broadway, Tucson, Arizona 85716, (520) 628-5188. If an employee chooses not to complete the reporting form, that employee may be at risk of losing a prima facie claim.

3. **NO LATER THAN TEN (10) CALENDAR DAYS** after the possible significant exposure the employee has blood drawn, and **NO LATER THAN THIRTY (30) CALENDAR DAYS** the blood is tested for **HIV OR HEPATITIS C** by antibody testing and the test results are negative.

4. **NO LATER THAN EIGHTEEN (18) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are HIV positive or the employee has been diagnosed as positive for the presence of HIV, or **NO LATER THAN SEVEN (7) MONTHS** after the date of the possible significant exposure at work, the employee is retested and the results of the test are positive for the presence of Hepatitis C or the employee has been diagnosed as positive for the presence of Hepatitis C.

KEEP POSTED IN CONSPICUOUS PLACE
NEXT TO WORKERS' COMPENSATION NOTICE TO EMPLOYEES

THIS NOTICE APPROVED BY THE INDUSTRIAL
COMMISSION OF ARIZONA FOR CARRIER USE

ICA Form 04-615-01
08 10 0574 (8-01)

TO BE POSTED BY EMPLOYER

POLICY NUMBER (13)7575-25-17

NOTICE TO EMPLOYEES

RE: ARIZONA WORKERS' COMPENSATION LAW

All employees are hereby notified that this employer has complied with the provisions of the Arizona Workers' Compensation law (Title 23, Chapter 6, Arizona Revised Statutes) as amended, and all the rules and regulations of The Industrial Commission of Arizona made in pursuance thereof, and has secured the payment of compensation to employees by insuring the payment of such compensation with: CHUBB INDEMNITY INSURANCE COMPANY

All employees are hereby further notified that in the event they do not specifically reject the provisions of the said compulsory law, they are deemed by the laws of Arizona to have accepted the provisions of said law and to have elected to accept compensation under the terms thereof; and that under the terms thereof employees have the right to reject the same by written notice thereof prior to any injury sustained, and that the blanks and forms for such notice are available to all employees at the office of this employer.

* *

PARA SER COLOCADO POR EL PATRON

NUMERO DE POLIZA (13)7575-25-17

AVISO A LOS EMPLEADOS

RE: LEY DE COMPENSATION PARA LOS TRABAJADORES DE ARIZONA

A todos los empleados se les notifica por este medio que este patron ha cumplido con las provisiones de la Ley de Compensacion para los Trabajadores de Arizona (Titulo 23, Capitulo 6, Estatutos Enmendados de Arizona) tal como han sido anmendados, y con todas las regias y ordenanzas de La Comission Industrial de Arizona hechas en cumplimiento de esta, y ha asegurado el pago de compensacion a los empleados garatizando el pago de dicha compensacion por medio de; CHUBB INDEMNITY INSURANCE COMPANY

Ademas, a todos los empleados se les notifica por este medio que en caso de que especificamente ellos no rechazen las disposicions de dicha ley obligatoria, se les considerara bajo las leyes de Arizona de haber eceptado las provisiones de dicha ley y de haber escogido aceptar la compensacion bajo estos terminos; tambien bajo estos terminos los empleados tienen el derecho de rechaza la misma por medio de una notificacion por escrito antes de que sufran alguna lesion, todos los formularios o formas en blanco para tal notificacion por escrito estaran disponibles para todos los empleados en la oficina de este patron.

* *

KEEP POSTED IN A CONSPICUOUS PLACE
COLOQUESE EN LUGAR VISIBLE

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20, 21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.
2. You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.
3. You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1. You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).
2. You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53,I).
3. You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53, I and II).
4. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.
5. All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.
6. You are required to obtain from the carrier identified below a supply of all required workers' compensation forms.

NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

James D. Casey
Labor Commissioner

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company or self-insurer:

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Name of Employer:

PAMLAB INC.

By _____

720509664

Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

WCP-1 (1-99) Prescribed by Labor Commissioner
State of New Hampshire

08 10 0584 (1-99)

WORKERS' COMPENSATION WORKPLACE NOTICE

Your employer is required to provide for payment of benefits under the Workers' Compensation Act of the state of West Virginia Code 23-2C-15(c).

Any employee who is injured while at work should report the injury immediately to their supervisor, employer, or designated representative.

The workers' compensation insurance carrier or the claims administrator for

CHUBB INDEMNITY INSURANCE COMPANY — PAMLAB INC.

(name of company) — *(name of insurance carrier or administrator)*

2800 POST OAK BLVD

(mailing address)

SUITE 2400

(city, state, zip)

HOUSTON, TX 77056-6118

(employer contact person)

(telephone number)

Any questions please contact:

Christine Pollitt - Philadelphia WC Claims Office
Four Penn Center
1600 John F. Kennedy Blvd.
Philadelphia PA 19103-2808

(215) 981-8368

TO BE POSTED BY EMPLOYER

08 10 0646 (Ed. 7/08)

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION

1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

08 10 0653 (Ed. 11/03)

WORK EXPOSURE TO METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA), SPINAL MENINGITIS, OR TUBERCULOSIS (TB)

Notice to Employees

Employees are notified that a claim may be made for a condition, infection, disease or disability involving or related to MRSA, spinal meningitis, or TB within the provisions of the Arizona Workers' Compensation Law. (A.R.S. § 23-1043.04) Such a claim shall include the occurrence of a significant exposure at work, which is defined to mean an exposure in the course of employment to aerosolized MRSA, spinal meningitis or TB bacteria. Significant exposure also includes exposure in the course of employment to MRSA through bodily fluids or skin.

Certain classes of employees (as defined below) may more easily establish a claim related to MRSA, spinal meningitis or TB by meeting the following requirements:

1. The employee's regular course of employment involves handling or exposure to MRSA, spinal meningitis or TB. For purposes of establishing a claim under this section, "employee" is limited to firefighters, law enforcement officers, correction officers, probation officers, emergency medical technicians and paramedics who are not employed by a health care institution;

2. No later than 10 days after a possible significant exposure, the employee reports in writing to the employer the details of the exposure;

3. A diagnosis is made within the following time-frames:

    a. For a claim involving MRSA, the employee is diagnosed with MRSA within two to ten days of the possible significant exposure;

    b. For a claim involving spinal meningitis, the employee is diagnosed with spinal meningitis within two to eighteen days of the possible significant exposure; and

    c. For a claim involving TB, the employee is diagnosed with TB within twelve weeks of the possible significant exposure.

Expenses for post-exposure evaluation and follow-up, including reasonably required prophylactic treatment for MRSA, spinal meningitis, and TB is considered a medical benefit under the Arizona Workers' Compensation Act for any significant exposure that arises out of and in the course of employment if the employee files a claim for the significant exposure or the employee reports in writing the details of the exposure. Providing post-exposure evaluation and follow-up, including prophylactic treatment, does not, however, constitute acceptance of a claim for a condition, infection, disease or disability involving or related to a significant exposure.

Employers must post this notice in a conspicuous place next to the Workers' Compensation Notice to Employees.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or, (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers.

A. CORPORATION / LIMITED LIABILITY COMPANY

I, _____ (Type or Print Name), certify that I am a member of _____ (Employer)

_____ (Office Held) _____ (Street Address)

☐ I elect to reject the provisions of the Georgia Workers' Compensation Law. _____ (City / State / Zip Code)

☐ I elect to revoke the previous rejection of _____ (Date)

(NOTE: A maximum of five (5) officers / members may be exempted)

B. SOLE PROPRIETOR OR PARTNER

I, _____, certify that I am a ☐ Sole Proprietor of _____ (Business Name)

☐ Partner

☐ I elect to be covered under the provisions of the Georgia Workers' Compensation Law.

☐ I elect to revoke the previous election of _____ (Date)

C. FARM LABOR

I, _____, certify that as the employer or representative of _____ (Business Name), that

☐ I elect to provide Workers' Compensation coverage for farm laborers.

☐ I elect to revoke the previous election of _____ (Date)

D. CERTIFICATION

☐ I hereby certify that the information listed is true and correct

Print Name	Business Phone Number and Ext.	Signature

Business Address

Dated this _____ Day of _____ (Month) / _____ (Year)

A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO NOT SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of DELAWARE **, hereby gives notice to their employees that they have secured the payment of Compensation to their employees and their dependents in accordance with the provisions of said law, by insuring with**

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

PAMLAB INC.
Employer

Dated _____ **By** _____

Form 08-10-0207 (Rev. 6/94)

NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of IOWA **, hereby gives notice to their employees that they have secured the payment of Compensation to their employees and their dependents in accordance with the provisions of said law, by insuring with**

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

PAMLAB INC.
Employer

Dated _____ **By** _____

Form 08-10-0207 (Rev. 6/94)

NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of KENTUCKY **, hereby gives notice to their employees that they have secured the payment of Compensation to their employees and their dependents in accordance with the provisions of said law, by insuring with**

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

PAMLAB INC.
Employer

Dated _____ **By** _____

Form 08-10-0207 (Rev. 6/94)

NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of MICHIGAN **, hereby gives notice to their employees that they have secured the payment of Compensation to their employees and their dependents in accordance with the provisions of said law, by insuring with**

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

PAMLAB INC.
Employer

Dated _____ **By** _____

Form 08-10-0207 (Rev. 6/94)

NOTICE

The undersigned, an employer within the meaning of the Workers' Compensation Law of the State of NEBRASKA **, hereby gives notice to their employees that they have secured the payment of Compensation to their employees and their dependents in accordance with the provisions of said law, by insuring with**

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

PAMLAB INC.
Employer

Dated _____ **By** _____

Form 08-10-0207 (Rev. 6/94)

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [PAMLAB INC.] **has** workers' compensation insurance coverage from [CHUBB INDEMNITY INSURANCE COMPANY] to protect you in the event of work-related injury or illness. This coverage is effective from [08/19/12]. Any injuries or illnesses which occur on or after that date will be handled by [CHUBB INDEMNITY INSURANCE COMPANY]. An employee or a person acting on the employee's behalf must notify the employer of an injury or illness not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an illness, unless the Division determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

Name of Employer

Name of commercial insurance company

Effective date of policy

Name of commercial insurance company

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [PAMLAB INC.] **tiene**
Nombre del empleador

cobertura de seguros de compensación para trabajadores con [CHUBB INDEMNITY INSURANCE COMPANY]
Nombre de la compañía de seguros

para protegerlo en caso de una lesión o enfermedad relacionada con su trabajo. Esta cobertura está vigente desde el [08/19/12]. Cualquier lesión o enfermedad,
Fecha en que entra en vigencia la póliza

que ocurra en o a partir de esta fecha será manejada por [CHUBB INDEMNITY INSURANCE COMPANY].
Nombre de la compañía de seguros

El empleado o la persona que lo representa debe notificar al empleador cuando el empleado sufre una lesión o enfermedad en el trabajo a no más tardar de treinta (30) días después de que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad, al menos que la División determine que existe un buen motivo para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador está obligado a proporcionarle información acerca de la cobertura de seguro de compensación, por escrito cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO:

La División le proporciona información gratuita sobre como someter un reclamo de compensación para trabajadores. El personal de la División le explicará cuales son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores de Texas y le asistirá para resolver disputas relacionadas con su reclamo. Usted puede obtener este tipo de asistencia comunicándose con la oficina local de la División al teléfono 1-800-252-7031.

LÍNEA PARA REPORTAR CONDICIONES INSEGURAS :

La División ha establecido una línea gratuita telefónica que está en servicio las 24 horas del día, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen al empleado o empleada porque el o ella, de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

EMPLEADORES CON COBERTURA:

Según el Reglamenta 110.101(e)(1), el Aviso 6 del Departamento de Seguros de Texas, División de Compensación para Trabajadores, requiere que usted informe a sus empleados acerca de que tiene cobertura de seguros de compensación para trabajadores por medio de una compañia de seguros comercial y debe informar también a los empleados acerca de la línea gratuita de información de la División de Compensación para Trabajadores para obtener información adicional acerca de sus derechos de compensación para trabajadores.

Avisos en Inglés, Español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista del público y:

(1) Mostrar muy a la vista en un lugar de la oficina de personal del empleador, si es que la hay;

(2) Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;

(3) El título debe ser impreso en tamaño 30, letra negrita de punto, el tema debe ser impreso en tamaño 20, con letra negrita de punto, y el texto, por lo menos en tamaño 19 punto tipo normal.

(4) Debe contener las palabras exactas como se ha señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requerimientos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la ley y reglamentos de la División.

NO MOSTRAR ESTE LADO

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [PAMLAB INC.] ha elegido
Nombre del Empleadorn

no obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común" de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensacion para trabajadores.

LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o descriminen contra un empleado o empleada porque él o ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

NOTICE OF ELECTION TO BE EXEMPT

Please refer to the written instructions prepared by the Division of Workers' Compensation before completing this form.

By filing this application, you elect to be exempt from the provisions of Chapter 440, Florida Statutes and waive any right you may have to workers' compensation benefits in the State of Florida should you become injured on the job. Any person who knowingly and with intent to injure, defraud, or deceive the Division or any employer, employee, or insurance company or purposes program, files a Notice of Election to be Exempt containing any false or misleading information is guilty of a felony of the third degree. Certain documentation is required by law to be attached to this application-refer to the instruction sheet for more details.

STATE USE ONLY

Effective/Issue Date: _____

Expiration Date: _____

Control Number: _____

Postmark Date: _____

Received Date: _____

I am applying for exemption as a (check only one box in this section):

CONSTRUCTION INDUSTRY ($ 50.00 FEE REQUIRED)

☐ Sole Proprietor ☐ Partner ☐ Corporate Officer (your corp. title:_____) **-OR-**

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Corporate Officer (your corp. title:_____)

CORPORATE OFFICERS AND PARTNERS: List the registration number of your business on file with the Division of Corporations, Department of State's Office (NOTE: your partnership may not have one, but all corporations must have one. If your partnership doesn't have one, state "N/A"):_____

THIS EXEMPTION APPLIES ONLY TO THE PERSON SIGNING THE APPLICATION AND ONLY TO THE BUSINESS ENTITY LISTED IN THE FOLLOWING SECTION

Business Name:		Trade Name; d/b/a; or a/k/a:		
Business Mailing Address:		City:	State:	Zip:
County:	Phone No.: ( )	Nature of Business:	FEIN:	
Unemployment Compensation Tax No:	Date Business Established:	No. of Employees:		

Are you required to be registered or certified pursuant to Chapter 489, F.S.? ☐ No ☐ Yes: list all certified or registered licenses issued to you pursuant to Chapter 489, Florida Statues _____

Are you or a qualifier for your business required by the county or the municiplity in which your business mailing address is located to have an occupational license for the business which is the subject of this application? ☐ No ☐ Yes:

YOU MUST ATTACH A COPY OF A CURRENT OCCUPATIONAL LICENSE

Are you employed by any sole proprietorship, partnership, corporation or business entity other than the business to which this application applies? ☐ NO ☐ YES list the name of all other businesses in which you are employed: _____

Has the above-referenced business entity been in operation long enough to have filed with or be required to file by the IRS, an annual Federal Income Tax Return? ☐ No ☐ Yes, You must attach tax records. See instruction sheet for details.

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers or partners as provided in §440.02 Florida Statutes; and that I will secure the payment of workers' compensation benefits, pursuant to Chapter 440, Florida Statues, for any employee I now have or may hereinafter acquire, for which my business is required by Florida law to secure such benefits.

_____ _____/_____/_____ _____/_____/_____

TYPE/PRINT NAME OF PERSON APPLYING FOR EXEMPTION **SOCIAL SECURITY NO.** **mo. day yr. DATE OF BIRTH**

_____ _____/_____/_____

APPLICANT'S SIGNATURE **DATE SIGNED**

NOTARY STATE OF FLORIDA, COUNTY OF_____

Sworn to and subscribed before me this _____ day of _____, _____, by _____

Personally Known _____ OR Produced Identification _____ Type of Identification Produced _____

NOTARY SIGNATURE _____ My Commission Expires _____

LES FORM BCM-250 Revised February 2000 **(SEE REVERSE FOR ADDITIONAL INFORMATION)**

CONSTRUCTION INDUSTRY APPLICANTS:
YOU MUST ATTACH A $50.00 PROCESSING FEE TO THIS FORM

Please refer to the written instructions prepared by the Division of Workers' Compensation before completing this form. (instruction sheets are available at the offices listed below)

THIS APPLICATION WILL NOT BE PROCESSED UNLESS ALL REQUIRED DOCUMENTATION AND FEES ARE ATTACHED TO IT.

SUBMIT THIS FORM ALONG WITH ALL ATTACHMENTS AND A $50.00 PROCESSING FEE (CONSTRUCTION INDUSTRY APPLICANTS ONLY) TO THE DISTRICT OFFICE LISTED BELOW THAT IS CLOSEST TO YOUR PLACE OF BUSINESS:

WORKERS' COMPENSATION COMPLIANCE FIELD OFFICES

11700 SAN JOSE BLVD.
SUITE # 3
JACKSONVILLE, FL 32223
TELEPHONE #(904) 448-7990

2810 SHARER RD.
SUITE # 27
TALLAHASSEE, FL 32312
TELEPHONE # (850) 414-1237 or # (850) 488-2717

3670-A NORTH L STREET
1ST FLOOR
PENSACOLA, FL 32505-5217
TELEPHONE # (850) 595-5505

1415 EAST SUNRISE BLVD.
SUITE # 300A
FT. LAUDERDALE, FL 33304
TELEPHONE # (954) 467-4610

9215 N. FLORIDA AVE.
SUITE # 107
TAMPA, FL 33612
TELEPHONE # (813) 930-7558

400 WEST ROBINSON ST
RM. # 601 NORTH TOWER
ORLANDO, FL 32801
TELEPHONE # (407) 245-0896

4603 NW 6th ST
GAINESVILLE, FL 32609
TELEPHONE # (352) 955-2018

1002 W 23rd ST
SUITE # 230
PANAMA CITY, FL 32405
TELEPHONE # (850) 747-5425

3111 SOUTH DIXIE HWY.
SUITE # 123
WEST PALM BEACH, FL 33405
TELEPHONE # (561) 837-5412

12381 S. CLEVELAND AVE.
SUITE # 506
FT. MYERS, FL 33907
TELEPHONE # (941) 278-7239

1718 MAIN ST.
SUITE # 201
SARASOTA, FL 34236
TELEPHONE # (941) 361-6025 OR # (941) 361-6021

401 NW 2nd AVE.
SUITE # 321-S
MIAMI, FL 33128
TELEPHONE # (305) 377-5385

INTERNET ACCESS TO THE DIVISION OF WORKERS' COMPENSATION

http://www.wc.les.state.fl.us/DWC/

LES FORM BCM-250-R Revised February 2000

INSTRUCTIONS FOR COMPLETING
CONSTRUCTION INDUSTRY APPLICATION FOR EXEMPTION
(Notice of Election to be Exempt – LES Form BCM – 250)

Who is Eligible for Exemption

The following classes of construction industry business owners are eligible for exemption from the provisions of Chapter 440, Florida Statutes (Florida's Workers' Compensation Law). If you apply for and receive an exemption, it means that you choose to NOT be eligible for workers' compensation benefits if you are hurt on the job. Note the limit on the number of partners and corporate officers from a single business actively engaged in the construction industry that can be exempt at any one time:

Sole Proprietors – Limit of 1
Partners – Limit of 3
Corporate Officers – Limit of 3

You must choose only one option and check only one box on your application to indicate which of the above three classes apply to you. If your business owner class changes after your exemption has been issued, your exemption will become invalid and you will have to apply for a new one. Non-construction industry sole proprietors and partners are AUTOMATICALLY EXEMPT by law, from the provisions of Chapter 440, Florida Statutes (Florida's Workers' Compensation Law). Officers of non-construction industry corporations are ELIGIBLE for exemption from the provisions of Chapter 440, Florida Statutes but must affirmatively apply for such an exemption by filing with the Division of Workers' Compensation a Notice of Election to be Exempt (LES Form BCM-250). An exemption applies ONLY to the applicant and not to any employees of the applicant. It applies ONLY to applicant FOR THE BUSINESS ENTITY listed on the application. You must submit a separate application for each business from which you wish to claim an exemption to workers' compensation benefits.

Application Fees

Every application must be accompanied by the appropriate fee. Failure to tender the appropriate fee with your application will mean that your application WILL NOT BE PROCESSED. Payment must be made by **BUSIESS CHECK, CASHIER'S CHECK, OR MONEY ORDER** made payable to the **W.C. ADMINISTRATION TRUST FUND.** The fees are:

$50.00 NON-REFUNDABLE PROCESSING FEE FOR EACH INITIAL OR RENEWAL APPLICATION

Effective Date and Expiration Date

Applications for an exemption by a business owner in a construction industry (Notice of Election to be Exempt, LES Form BCM 250) will be processed within thirty days after the date the application is mailed to the Division as evidenced by the postmark on the envelope in which the application is mailed. In the event that a postmark is not present or not legible, or an application is delivered to the Division by other than U.S. Mail, the application will be processed within thirty days from the date it is received by the Division. Once an application is processed, if an exemption is issued, it will be effective as of the date following the day the application is mailed or received. Every exemption will be marked with an effective date, and will expire two years from that effective date, unless voluntarily revoked by the exemption holder or involuntarily revoked by the Department of Labor, Division of Workers' Compensation.

Your exemption will be valid for two years from the date it is issued. It will automatically expire at the end of that two year period, and you will have to reapply for another exemption. However, your exemption shall be revoked by the Division if it is determined by the Division at any time that you are no longer eligible for the exemption or that information contained in your application or any attachment to it was invalid. You may voluntarily revoke your own exemption at any time by filing with the Division LES Form BCM-250-R, Revocation of Election to be Exempt.

Federal Employer Identification Number (FEIN)

A Federal employer identification number is required of all partners (provide your partnership's FEIN) and corporate officers (provide your corporation's FEIN), and sole proprietors with employees (provide the proprietorship's FEIN). To acquire a federal employer identification number, contact the **Internal Revenue Service.**

******** INSTRUCTIONS ARE CONTINUED ON REVERSE *********

ALL APPLICANTS for a construction industry exemption must attach a copy of the relevant occupational license issued to the applicant by the Florida county in which the applicant's principal place of business is located (usually the business mailing address); or the county in which the applicant conducts his principal business operations. If the county does not require an occupational license, then the applicant must attach a copy of the relevant occupational license issued to the applicant by the municipality in which the applicant's principal pace of business is located; or the municipality in which the applicant conducts their principal business operations. OUT OF STATE EMPLOYERS – If your business is domiciled in a state other than Florida you must provide a copy of an occupational license issued by the Florida county or municipality in which you conduct your principal business operations. **AND...**

- **CORPORATE OFFICERS NOT YET LISTED AS SUCH** on the records of the Secretary of State, Division of Corporations, the applicant must attach a notarized affidavit stating that the applicant is a bona fide officer of the corporation and stating the date such appointment or election became or shall become effective. **AND...**

- **SOLE PROPRIETORS** must attach a copy of: *

1. An IRS FORM 1040 filed by your BUSINESS with the IRS for the most recent tax year;
2. An IRS SCHEDULE C filed by your BUSINESS with the IRS for the most recent tax year. **AND...**

- **PARTNERS** must attach a copy of: *

1. An IRS FORM 1040 filed by your PARTNERSHIP with the IRS for the most recent tax year;
2. An IRS SCHEDULE K-1 (FORM 1065) filed by your PARTNERSHIP with the IRS for the most recent tax year;
3. An IRS SCHEDULE E filed by your PARTNERSHIP with the IRS for the most recent tax year;

*** EXCEPTION FOR NEW BUSINESSES:** A sole proprietor or partner of a business entity that has not been in operation long enough to have filed or be required to file by the IRS its first annual Federal Income Tax return does not need to attach tax records to the notice of election to be exempt.

Mail or take your application to the workers' compensation compliance field office nearest your business location. Faxed copies will not be processed. **Failure to completely and legibly submit all information, attachments and fees required with an application for an exemption or to include a notarized signature of the applicant will result in the application not being processed.** Fees will not be returned for unprocessed applications.

WORKERS' COMPENSATION COMPLIANCE FIELD OFFICES

11700 SAN JOSE BLVD.
SUITE # 3
JACKSONVILLE, FL 32223
TELEPHONE #(904) 448-7990

2810 SHARER RD.
SUITE # 27
TALLAHASSEE, FL 32312
TELEPHONE # (850) 414-1237 or # (850) 488-2717

3670-A NORTH L STREET
1ST FLOOR
PENSACOLA, FL 32505-5217
TELEPHONE # (850) 595-5505

1415 EAST SUNRISE BLVD.
SUITE # 300A
FT. LAUDERDALE, FL 33304
TELEPHONE # (954) 467-4610

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400 WEST ROBINSON ST
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TELEPHONE # (407) 245-0896

4603 NW 6th ST
GAINESVILLE, FL 32609
TELEPHONE # (352) 955-2018

1002 W 23rd ST
SUITE # 230
PANAMA CITY, FL 32405
TELEPHONE # (850) 747-5425

3111 SOUTH DIXIE HWY.
SUITE # 123
WEST PALM BEACH, FL 33405
TELEPHONE # (561) 837-5412

12381 S. CLEVELAND AVE.
SUITE # 506
FT. MYERS, FL 33907
TELEPHONE # (941) 278-7239

1718 MAIN ST.
SUITE # 201
SARASOTA, FL 34236
TELEPHONE # (941) 361-6025 OR # (941) 361-6021

401 NW 2nd AVE.
SUITE # 321-S
MIAMI, FL 33128
TELEPHONE # (305) 377-5385

INTERNET ACCESS TO THE DIVISION OF WORKERS' COMPENSATION
http://www.fdles.state.fl.us/wc/

CONSTRUCTION INDUSTRY INSTRUCTIONS FOR LES FORM BCM-250 Revised February 2000

COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

La ley requiere que cada persona que trabaja en este lugar o que proporciona servicios relacionados con este proyecto de construcción debe estar cubierta por un seguro de compensación para trabajadores. Esto incluye a personas que proporcionan, transportan, o entregan equipo o materiales, o que proporcionan mano de obra, u otros servicios relacionados con este proyecto, sin importar la identidad del empleador o el estado como empleado.

Comuníquese con la División de Compensación para Trabajadores al teléfono 512-804-4345 para recibir información referente a los requerimientos legales de cobertura, para verificar si su empleador ha proporcionado la cobertura requerida, o para reportar a un empleador que no proporciona cobertura.

AL EMPLEADOR / CONTRATISTA:

Según el Reglamento de Compensación para Trabajadores 110.110 (d)(7), requiere que un contratista que está involucrado en el proyecto de construcción de un edificio de entidad gubernamental muestre este aviso en cada lugar donde se lleva a cabo el proyecto para así informar a todos las personas que proporcionan servicios en el proyecto que se les debe proporcionar un seguro de compensación para trabajadores. El aviso presentado aquí no satisface otros avisos de requerimientos impuestos por la Ley de Compensación para Trabajadores de Texas o otros Reglamentos de Compensación para Trabajadores. Este aviso debe:

(1) ser mostrado en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador;
(2) ser mostrado en cada área de trabajo en el proyecto;
(3) explicar como una persona puede verificar la cobertura actual del empleador y como reportar si el empleador no ofrece cobertura;
(4) ser impreso con un título en por lo menos tamaño 30, con letra negrita de punto, y el texto en por lo menos tamaño 19 en punto tipo normal; y
(5) contener las palabras exactas como se ha señalado en el Reglamento 110.110 (d)(7).

El aviso que se muestra al reverso de esta página cumple con los requisitos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la Ley y Reglamentos de Compensación para Trabajadores. El infractor puede estar sujeto a penalidades administrativas.

NON-COVERED EMPLOYER:

Texas Workers' Compensation Rule 110.101(e)(3) requires employers who elect not to be covered by workers' compensation, or who cancel or terminate coverage to advise their employees that they have elected not to be covered.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

(1) Prominently displayed in the employer's personnel office, if any;

(2) Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;

(3) Printed with a title in at least 30 point bold type, subject in at least 20 point bold type, and text in at least 19 point normal type; and

(4) Contain the exact words as prescribed in Rule 110.101(e)(3).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

DO NOT POST THIS SIDE

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (PAMLAB INC.) has elected not to
Name of Employer

obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

CHUBB

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 insurers 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 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. Your insurer or the insurer's authorized representative must explain to you why a particular employee classification was used to eliminate any possible confusions within thirty (30) days after receipt of your request for information.

   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, c/o National Council on Compensation Insurance, Inc. (NCCI), 7220 West Jefferson Avenue, Suite 310, Lakewood, CO 80235. 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

   Because there are different types of case management services available and prescribed by insurers, it is suggested that each insurer include the type of case management services available by the individual insurer.

CHUBB

FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

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 for each policy period in which you would like to receive the credit and forward it to your insurer.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

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

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

Notice of Employer's Drug Testing Policy:

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

Education:

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

Name of Medical Review Officer: _____

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

_____

B. Phone No.: ( ) _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

_____ Employer Name

_____ Date

_____ Officer/Owner Signature*

_____ Title

*Application must be signed by an officer or owner.

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM.

_____ Notary Public's Signature

_____ Date

_____ Expiration of Commission

CHUBB

POLICYHOLDER INFORMATION NOTICE

To Our Missouri Policyholders:

If you have a question about your insurance policy, you may contact your agent or broker, or call us directly by using our toll-free number. We are required by Missouri state law to advise you of this with the following announcement:

This notice is being provided to you pursuant to requirements of Section 23 House Bill number 1574(1992) 375-924 of the revised statutes of Missouri, relating to our toll-free information and complaint number. Please keep this notice with your other important insurance documents.

FOR INFORMATION, OR
TO MAKE A COMPLAINT, CALL:
1-800-36 CHUBB

Our Missouri location addresses are:

Kansas City Branch

1100 WALNUT
SUITE 1800
KANSAS CITY, MO 64106
(816)292-4500

St. Louis Branch

8000 MARYLAND AVENUE
SUITE 1500
ST. LOUIS, MO 63105-3913
(314)889-4400

Very truly yours,
Chubb Group of Insurance Companies
HOUSTON
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

CHUBB

Notification to Policyholders of Accident Prevention Services – Arkansas

The Chubb Group of Insurance Companies is required to provide its policyholders with certain accident prevention services at no additional cost as required by Ark. Code Ann. § 11-9-409 (d) and AWCC Rule 32. If you would like more information, call 1-877-248-2202. If you have any questions about this requirement, call the Health and Safety Division, Arkansas Workers' Compensation Commission at 1-800-622-4472.

- **Please note that you may also email your request for Chubb accident prevention services by addressing your email to: *loss_control_service@chubb.com***
- **If you call and leave a message or send an email request, please include your name, phone number, company name, and workers compensation policy number.**

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.

P.O. BOX 8950
MANDEVILLE LA 70470

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY

N.C.C.I. Carrier Code 31720

Endorsement Number

FRAUD NOTICE - OKLAHOMA/WARNING

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.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

CHUBB

NOTIFICATION OF AVAILABLE LOSS CONTROL SERVICES

MISSOURI WORKERS' COMPENSATION POLICYHOLDERS

CHUBB GROUP OF INSURANCE COMPANIES

You are hereby notified that loss control services are available, upon request, to workers' compensation policyholders with employees working in Missouri. The services are intended to provide employers with appropriate resources to address workplace safety and health issues and reduce insured losses through a safety engineering and management program. This notice is provided pursuant to the requirements of Missouri Law. If you would like more information, call 1-877-248-2202 or email *loss_control_service@chubb.com.* If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

The Missouri Division of Workers' Compensation offers free safety services to Missouri employers through its Missouri Workers' Safety Program (MWSP). MWSP's main goal is to help employers control workers' compensation costs. The Division also certifies Missouri insurance carriers' safety engineering and management programs that are available to insured's upon request. Employers may contact MWSP at 1(800)775-COMP or 573-526-3504, email *mowsp@dolir.mo.gov* for more information about workplace safety or for a registry of safety consultants and safety engineers who are certified by the Division.

CHUBB

NOTICE TO COLORADO WORKERS' COMPENSATION POLICYHOLDERS

As a Colorado employer, you should be aware of the availability of the Workers' Compensation Premium Cost Containment Certification Program. This program provides for potential premium savings for those employers who become certified by the Colorado Premium Cost Containment Board.

If you wish to participate in the certification program to reduce injuries and workers' compensation cost, the Workers' Compensation Cost Containment Board offers a detailed manual containing forms, check lists, sample rules and other information to achieve certification status.

For information Contact:

Workers' Compensation Premium Cost Containment Board
633 17th Street, Suite 400
Denver, CO 80202 - 3660
(303) 318-8644

CHUBB

IMPORTANT NOTICE

KANSAS WORKERS' COMPENSATION POLICYHOLDERS

In compliance with KSA 44-5104, entitled Kansas Workers Compensation Law, our accident prevention services, which meet the standards of that law, are available to you upon request.

If you would like more information call 1-877-248-2202 or email *loss_control_service@chubb.com*. If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

CHUBB

NEW YORK

APPLICATION FOR DRUG FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Address of Employer: _____

Please attach a copy of employer's written substance abuse policy

Education:

____ Supervisory training How long _____

____ Employee education How long _____

____ Employee Assistance Program or Community health services directory

Name and address of Employee Assistance Program: _____ Phone #: _____

Notice of Employer's Drug Testing Policy:

____ Copy to all employees prior to testing

____ Posted on employer's premise

____ Copy to job applicant

_____ Show notice of drug testing on vacancy announcements

_____ Copies available in personnel office or other suitable locations.

Testing:

Drug Testing has been conducted in the following area: (check all that apply)

____ Job applications

____ Reasonable suspicion

Post Accident

____ Random testing

____ Follow-up to Employee Assistance Program/Rehabilitation

Name and address of Medical Review Officer: _____

_____ Phone # _____

Name and address of DHHS certified lab: _____

_____ Phone # _____

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

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM

_____	_____	_____
Notary Public's Signature	Date	Expiration of Commission

This application is to be completed, signed, notarized, and returned to your agent or broker, who will forward it to the carrier as proof of the existence of a certified program.

CHUBB

PRIVACY POLICY AND PRACTICES

THIS NOTICE IS BEING SENT TO THE WORKERS COMPENSATION PLAN PARTICIPANT (EMPLOYER). IT DESCRIBES CHUBB'S POLICY FOR HANDLING CERTAIN PERSONAL INFORMATION OF ITS INDIVIDUAL CUSTOMERS. THIS NOTICE IS PROVIDED TO THE EMPLOYER TO SATISFY CHUBB'S NOTICE OBLIGATIONS UNDER STATE LAW.

Chubb has been serving the insurance needs of our customers for more than a century. To continue to provide innovative products and services that respond to your insurance needs, Chubb collects certain personal information about you, which is described below in **The Personal Information We Collect**. At Chubb, we respect the privacy of our customers. Chubb's personal information handling practices are regulated by law, and this Privacy Policy describes those practices.

Chubb's Privacy Policy

The Personal Information We Collect. Chubb collects personal information about you and the members of your household to conduct business operations, provide customer service, offer new products, and satisfy legal and regulatory requirements.

We may collect the following categories of information about you from these sources:

- Information from you directly or through an agent, broker, or your employer, including information from applications, worksheets, questionnaires, claim forms or other documents (such as name, address and social security number);
- Information from a consumer reporting agency (such as motor vehicle reports);
- Information from other non-Chubb sources (such as prior loss information);
- Information from visitors to our web sites (such as that provided through online forms and online information-collecting devices known as "cookies"). Chubb does not use "cookies" to retrieve information from a visitor's computer that was not originally sent in a "cookie";
- Information from an employer, benefit plan sponsor, benefit plan administrator or master policyholder for any Chubb individual or group insurance product that you may have (such as name, address and social security number).

The Personal Information We Share. Chubb may disclose the personal information we collect to service, process, or administer business operations such as underwriting and claims, and for other purposes such as the marketing of products or services, regulatory compliance, the detection or prevention of fraud, or as otherwise required or allowed by law. These disclosures may be made without prior authorization from you, as permitted by law.

Sharing Personal Information With Others. Chubb may disclose the personal information we collect to affiliated and non-affiliated parties for processing and servicing transactions, such as reinsurers, insurance agents or brokers, auditors, claim adjusters, third party administrators and, in the case of workers compensation insurance, employers, benefit plan sponsors, benefit plan administrators or master policyholders. For example, Chubb may disclose personal information to our affiliates and other parties that perform services for us such as customer service or account maintenance. Specific examples include mailing information to you and maintaining or developing software for us. Chubb may also disclose personal information to nonaffiliated parties as permitted by law. For example, we may disclose information in response to a subpoena, to detect or prevent fraud or to comply with an inquiry or requirement of a government agency or regulator.

Sharing Personal Information With Service Providers or for Joint Marketing. Chubb may disclose the personal information we collect to agents and brokers so that they can market financial products and services, and to service providers who perform functions for us. Any such disclosure is required to be subject to an agreement with us that includes a confidentiality provision. We do not disclose personal information to other financial institutions with which we may have joint marketing arrangements; however, we reserve the right to do so in the future, subject to the other financial institution entering into an agreement with us that includes a confidentiality provision.

Confidentiality and Security of Personal Information. Access to personal information is allowed for business purposes only. The people who have access to personal information, including employees of Chubb and its affiliates, and non-employees performing business functions for Chubb, are under obligations to safeguard such information. Chubb maintains physical, electronic, and procedural safeguards to guard your personal information.

Personal Health Information. Under certain circumstances, we also collect personal health information about our customers, such as information regarding an accident, disability or injury, for underwriting or claim purposes. Chubb does not disclose your personal health information to others for the purpose of marketing to you unless we have your express consent.

Personal Information of Former Customers. Chubb's personal information privacy policy also applies to former customers.

Changes in Privacy Policy. Chubb may choose to modify this policy at any time. We will notify customers of any modifications at least annually.

Definitions.

"Customer" and "you" mean any individual who obtains or has obtained a financial product or service from Chubb that is to be used primarily for personal family or household purposes. This notice applies to customers only.

"Personal information" means nonpublic personal information, which is defined by law as personally identifiable financial information provided by you to Chubb, resulting from a transaction with or any service performed for you by Chubb, or otherwise obtained by Chubb. Personal information does not include publicly available information as defined by applicable law.

"Chubb" means the following companies on whose behalf this notice is given:

Chubb & Son Inc.
Chubb & Son Inc. (of Illinois)
Chubb Custom Insurance Company
Chubb Custom Market, Inc.
Chubb Indemnity Insurance Company
Chubb Insurance Company of New Jersey
Chubb Lloyds Insurance Company of Texas
Chubb Multinational Managers, Inc.
Chubb National Insurance Company
Executive Risk Indemnity Inc.
Executive Risk Specialty Insurance Company
Federal Insurance Company
Great Northern Insurance Company
Northwestern Pacific Indemnity Company
Pacific Indemnity Company
Quadrant Indemnity Company
Texas Pacific Indemnity Company
Vigilant Insurance Company

Chubb Group of Insurance Companies
Chubb Commercial Insurance
Workers Compensation
Attention: Privacy Inquiries
15 Mountain View Road
Warren, New Jersey, 07061-1615

CHUBB

IMPORTANT NOTICE

PENNSYLVANIA WORKERS' COMPENSATION POLICYHOLDERS

The Chubb Group of Insurance Companies 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 including information about the 5% premium discount available to employers who form a certified workplace safety committee.

If you would like more information, call 1-877-248-2202 or email *loss_control_service@chubb.com*. If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

CHUBB GROUP OF INSURANCE COMPANIES

Dear Policyholder:

As we previously communicated, California recently enacted workers compensation reform legislation that allows the employer/insurance carrier to direct care of injured employees to a Medical Provider Network (MPN), effective January 1, 2005.

As you know, Chubb selected CorVel's CorCare network to provide medical treatment for all work-related injuries in California. A Chubb business partner for several years, CorVel has been a certified Health Care Organization in California since 1997.

Chubb, utilizing CorVel's network, recently received approval by the California Division of Workers Compensation as an MPN. We have enclosed the final state approved Employee Notification Kit from CorVel with pertinent information on enrolling employees in the MPN. Due to regulations that were enacted between the time our application was filed and approved, this final version of the kit has some minor changes from the version you received previously.

This updated kit must be given to employees prior to implementing the MPN, at the time of hire, when an existing employee transfers into the MPN, or at the time of injury, whichever is appropriate to ensure that the employee has received the initial notification (Section 9767.12 of the California legislation, SB899). If you have already enrolled in the MPN, provide the updated kit to the employee at the time of injury. Please be advised that notification to all employees must be in both English and Spanish.

At Chubb, we believe that timely, quality medical care and early reporting of a claim is the best approach to containing your workers compensation costs. Participation in the Medical Provider Network will help support medical cost containment.

To find a medical center in the MPN, follow these steps:

- Go to http://www.corvel.com
- Click "PROVIDER LOOK-UP"
- Click "Find Providers Near You"
- Select "CorCare (CA-MPN)" and click "Continue"
- Enter your zip code and click "Continue"
- Under "3) HOSPITAL OR FACILITY SEARCH", choose "Occupational Medical Center" in the drop-down menus, then click "Continue"

This will provide you a list of medical clinics in your area that are part of the MPN.

Thank you for your cooperation.

Chubb Group of Insurance Companies
Warren, New Jersey 07059

CHUBB

EMPLOYEE'S NOTICE TO REJECT TERMS OF THE ARIZONA WORKER'S COMPENSATION LAW

POLICY NO. (13)7575-25-17 DATE 08/19/12

To PAMLAB INC.

(Full Name of Employer)

P.O. BOX 8950

MANDEVILLE LA 70470

(Address of Employer in Full)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

(Employee Print Name Here) (Social Security Number of Employee)

(Address of Employee) (Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the worker's compensation insurance carrier.

CHUBB

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF THE TERMS OF THE WORKER'S COMPENSATION LAW

POLICY NO. (13)7575-25-17 DATE 08/19/12

To PAMLAB INC.

(Full Name of Employer)

P.O. BOX 8950

MANDEVILLE LA

(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF THE TERMS OF THE WORKER'S COMPENSATION LAW SIGNED BY ME ON _____

(Employee Print Name Here)

(Social Security Number of Employee)

(Address of Employee)

(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the worker's compensation insurance carrier.

CHUBB

POLICY INFORMATION NOTICE

In accordance with Arkansas law, we are required to notify you of the address and telephone number of the Arkansas Insurance Department and our company's Policyholder Service Office. We are also required to give the name, address and telephone number of your agent or broker. They are:

Arkansas Insurance Department
Consumer Services Division
1200 West Third St.
Little Rock, Arkansas 72201
(501) 371-2640
(800) 852-5494

Chubb Group of Insurance Companies

Address: 2800 POST OAK BLVD

SUITE 2400

City, State, Zip Code: HOUSTON, TX 77056-6118

Telephone Number:

Agent or Broker

Name: STONE INSURANCE, INC.

Address: 1502 W.CAUSEWAY APPROACH

City, State, Zip Code: MANDEVILLE LA 70471

Telephone Number: (985) 626-1255

In all correspondence, please include your policy number and policy period.

Thank you.

CHUBB

POLICY INFORMATION NOTICE

There are times when we need information about you or the property we insure for you. We want you to understand why we need this and what we do with it.

Most of our information comes from your agent or broker. We may also collect personal information from other sources. This knowledge helps us underwrite and price the insurance policy correctly and keep our files current.

In order to protect your right to privacy we will not disclose information in our files about you without your prior consent except to those who have a direct interest in your insurance transactions such as your agent or broker, appraisers or organizations which conduct statistical profile research.

You have the right to review and correct or amend information we have. If you want to know more about this and how information may be disclosed without your prior authorization please write to:

Policy Information
CHUBB GROUP of Insurance Companies
15 Mountain View Road, P.O. Box 1615
Warren, New Jersey 07061-1615

Please include your policy number, policy period and the name and address of your agent or broker. Thank you.

Consumer Service Notice
If you have any problems with your policy you may contact:

Consumer Service Department
Chubb Group of Insurance Companies
220 South Riverside Plaza
Chicago, Illinois 60606

Illinois Department of Insurance
Consumer Services Section
320 West Washington Street
4th Floor
Springfield, Illinois 62767

CHUBB

NOTICE TO 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. We want to provide you with our Company's name, address and phone number as well as that of your Agent or Broker. They are:

Chubb Group of Insurance Companies

Address:	2800 POST OAK BLVD SUITE 2400
City, State, Zip Code:	HOUSTON, TX 77056-6118
Telephone Number:	

Agent or Broker

Name:	STONE INSURANCE, INC.
Address:	1502 W.CAUSEWAY APPROACH
City, State, Zip Code:	MANDEVILLE LA 70471
Telephone Number:	(985) 626-1255

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

In all correspondence, please include your policy number and policy period.

CHUBB

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Chubb's toll-free telephone number for information or to make a complaint at:

1-800-699-9916 - Information
1-800-873-0777 - Complaints

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the (agent) first.

If the dispute is not resolved, you may contact the Texas Department of Insurance.

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Chubb's para informacion o para someter una queja al:

1-800-699-9916 - Informacion
1-800-873-0777 - Una queja

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el (agente) primero.

Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

CHUBB

NOTICE TO POLICYHOLDERS

As our policyholder, your satisfaction is very important to us. If you have a question about your policy, if you need assistance with a problem, or if you have a claim, you should first contact your insurance agent or us at (317) 321-6000. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Should you feel you are not being treated fairly with respect to a claim, you may contact the Indiana Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787
317-232-2395 or 1-800-622-4461

CHUBB

IMPORTANT NOTICE TO POLICYHOLDERS
TERRORISM RISK INSURANCE ACT

This Important Notice is being provided with your policy to further satisfy the disclosure requirements of the Terrorism Risk Insurance Act.

At the time you received the written offer for this policy, we provided you with an Important Notice to Policyholders indicating that the insurance provided in your policy for losses caused by certain acts of terrorism (as defined in the Terrorism Risk Insurance Act) would be partially reimbursed by the United States of America, pursuant to the formula set forth in the Terrorism Risk Insurance Act. In addition, as required by the Terrorism Risk Insurance Act, we:

- indicated that we would make available insurance for such losses in the same manner as we provide insurance for other types of losses;
- specified the premium we would charge, if any, for providing such insurance; and
- except to the extent prohibited by law, gave you the opportunity to reject such insurance and have a terrorism exclusion, sublimit or other limitation included in your policy.

This Important Notice refers back to that Important Notice and provides information about your decision and the manner in which your policy has been subsequently modified.

If:

- You rejected terrorism insurance under the Terrorism Risk Insurance Act, your policy includes the appropriate amendatory endorsement(s).
- You did not reject terrorism insurance under the Terrorism Risk Insurance Act, the premium charged for your policy, including that portion applicable to terrorism insurance under the Terrorism Risk Insurance Act, is shown in your policy. To the extent your policy includes a limitation on terrorism insurance, it has been modified so that such limitation does not apply to terrorism insurance under the Terrorism Risk Insurance Act.

Please carefully review your policy and the Important Notice previously provided to you for further details. Please remember that only the terms of your policy establish the scope of your insurance protection.

Please note that if your policy:

- ***provides commercial property insurance in a jurisdiction that has a statutory standard fire policy, the premium we charge for terrorism insurance under the Terrorism Risk Insurance Act, includes an amount attributable to the insurance provided pursuant to that standard fire policy. Rejection of such statutory insurance is legally prohibited.***
- ***is a workers compensation policy, rejection of insurance for terrorism is legally prohibited.***

If aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed $100 billion in a Program Year (January 1 through December 31), the Treasury shall not make any payment for any portion of the amount of such losses that exceeds $100 billion.

If aggregate insured losses attributable to terrorist acts certified under the Terrorism Risk Insurance Act exceed $100 billion in a Program Year (January 1 through December 31) and we have met our insurer deductible under the Terrorism Risk Insurance Act, we shall not be liable for the payment of any portion of the amount of such losses that exceeds $100 billion, and in such case insured losses up to that amount are subject to pro rata allocation in accordance with procedures established by the Secretary of the Treasury.

CHUBB

IMPORTANT NOTICE

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your 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:

15 MOUNTAINVIEW ROAD
WARREN, NEW JERSEY 07059

1-800-36-CHUBB

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

1300 EAST MAIN STREET
RICHMOND, VIRGINIA 23219

877-310-6560

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.

CHUBB

FLORIDA NOTICE OF RISK MANAGEMENT PROGRAM AVAILABILITY

Florida regulations require us to develop and make available for use by our clients a Risk Management Guide. We are pleased to present to you Chubb's Risk Management Guide, which includes measures, services and plans we have developed. The scope of your Risk Management Program should include the following:

1. Safety measures, including, as applicable, the following areas:
   a. Pollution and environmental hazards;
   b. Disease hazards;
   c. Accidental occurrences;
   d. Fire hazards and fire prevention and detection;
   e. Liability for acts from the course of business;
   f. Slip and fall hazards;
   g. Products injury; and
   h. Hazards unique to a particular class or category of policyholders.
2. Training to policyholders in safety management techniques.
3. Safety management counseling services.

Our guide and services are available upon request to assist in your risk management efforts. If you would like more information call 1-877-248-2202 or email *loss_control_service@chubb.com.*

If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, policy number and a brief description of the loss control services being requested.

CHUBB

POLICYHOLDER NOTICE

All of the members of the Chubb Group of Insurance companies doing business in the United States (hereinafter "Chubb") distribute their products through licensed insurance brokers and agents ("producers"). Detailed information regarding the types of compensation paid by Chubb to producers on US insurance transactions is available under the Producer Compensation link located at the bottom of the page at www.chubb.com, or by calling 1-866-588-9478. Additional information may be available from your producer.

Thank you for choosing Chubb.

CHUBB

IMPORTANT NOTICE TO POLICYHOLDERS

THIS NOTICE IS NOT YOUR POLICY. PLEASE READ YOUR POLICY CAREFULLY TO DETERMINE YOUR RIGHTS, DUTIES, AND WHAT IS AND WHAT IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE .

PLEASE READ THIS NOTICE CAREFULLY.

In response to the Delaware Civil Union and Equality Act of 2011 (the "Act"), throughout your policy the term "spouse" means a spouse or a party to a civil union under the Act. We will be issuing an endorsement to your policy to that effect when it becomes available.

CHUBB

IMPORTANT NOTICE TO POLICYHOLDER – MINNESOTA

RE: Minnesota Workers Compensation Notice of Services

Dear Risk Manager:

As your workers compensation insurer, we are required under Minnesota law to provide you with safety consultation services for your Minnesota locations if you request such services in writing. If you desire safety consultation services, you may make a written request addressed as follows:

Chubb Group of Insurance Companies
100 South 5th Street
Suite 1800
Minneapolis, MN 55402-1800
Telephone Number: (612) 373-7300
Fax Number: (612) 373-7436
Attention: Loss Control Manager

Dear Policyholder,

Attached to this policy are various forms that must be completed by you. Please make the appropriate selection, sign the forms and return them to your agent or broker for transmittal to us as soon as possible.

Thank you for your cooperation.

Very truly yours,

Chubb Group of Insurance Companies

FLORIDA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE

Florida law requires that we provide a notice outlining the availability of a state-authorized $2,500 deductible plan for medical and indemnity expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY.

There is no premium credit associated with this option, but any amounts paid by the employer shall not apply to the experience rating of such employer.

REVOCATION OF ELECTION TO BE EXEMPT

STATE USE ONLY

Effective/Issue Date:

Control Number:

Postmark Date:

Received Date:

PLEASE TYPE OR PRINT

I hereby revoke an exemption I currently hold as a (check only one box in this section):

CONSTRUCTION INDUSTRY

☐ Sole Proprietor ☐ Partner ☐ Corporate Officer (your corporate title:_____) **-OR-**

NON-CONSTRUCTION INDUSTRY

☐ Corporate Officer (your corporate title:_____)

THIS REVOCATION OF ELECTION TO BE EXEMPT APPLIES ONLY TO THE PERSON SIGNING THE REVOCATION AND ONLY TO THE BUSINESS ENTITY LISTED IN THE FOLLOWING SECTION:

Business Name:		Trade Name;d/b/a; or a/k/a:		
Business Mailing Address:		City:	State:	Zip:
County:	Phone No.: ( )	Nature of Business:	FEIN:	
Unemployment Compensation Tax No:	Date Business Established:	No. of Employees:	Sec. Of State, Div. Of Corp. Reg. No.:	

I UNDERSTAND THAT IF I AM A SOLE PROPRIETOR, PARTNER, OR CORPORATE OFFICER AND I AM A SUBCONTRACTOR I MUST NOTIFY MY CONTRACTOR THAT I HAVE REVOKED MY EXEMPTION.

NOTIFICATION THAT YOU HAVE CHOSEN TO REVOKE YOUR EXEMPTION FROM CHAPTER 440, FLORIDA STATUTES SHALL BE GIVEN BY THE DIVISION TO ANY INSURER ON RECORD WITH THE DIVISION AS A PROVIDER OF WORKERS' COMPENSATION INSURANCE TO THE BUSINESS ENTITY NAMED HEREIN.

TYPE/PRINT NAME OF EXEMPTION HOLDER

SOCIAL SECURITY NO.

SIGNATURE OF EXEMPTION HOLDER

DATE SIGNED

LES FORM BCM-25-R Revised February 2000

SUBMIT THIS FORM TO THE DISTRICT OFFICE LISTED BELOW THAT IS CLOSEST TO YOUR PLACE OF BUSINESS:

WORKERS' COMPENSATION COMPLIANCE FIELD OFFICES

11700 SAN JOSE BLVD.
SUITE # 3
JACKSONVILLE, FL 32223
TELEPHONE #(904) 448-7990

2810 SHARER RD.
SUITE # 27
TALLAHASSEE, FL 32312
TELEPHONE # (850) 414-1237 or # (850) 488-2717

3670-A NORTH L STREET
1ST FLOOR
PENSACOLA, FL 32505-5217
TELEPHONE # (850) 595-5505

1415 EAST SUNRISE BLVD.
SUITE # 300A
FT. LAUDERDALE, FL 33304
TELEPHONE # (954) 467–4610

9215 N. FLORIDA AVE.
SUITE # 107
TAMPA, FL 33612
TELEPHONE # (813) 930-7558

400 WEST ROBINSON ST
RM. # 601 NORTH TOWER
ORLANDO, FL 32801
TELEPHONE # (407) 245-0896

4603 NW 6TH ST
GAINESVILLE, FL 32609
TELEPHONE # (352) 955-2018

1002 W 23RD ST
SUITE 230
PANAMA CITY, FL 32405
TELEPHONE # (850) 747-5425

3111 SOUTH DIXIE HWY.
SUITE # 123
WEST PALM BEACH, FL 33405
TELEPHONE # (561) 837-5412

12381 S. CLEVELAND AVE.
SUITE # 506
FT. MYERS, FL 33907
TELEPHONE # (941) 278-7239

1718 MAIN ST.
SUITE # 201
SARASOTA, FL 34236
TELEPHONE # (941) 361-6025 OR # (941) 361-6021

401 NW 2nd AVE.
SUITE # 321-S
MIAMI, FL 33128
TELEPHONE # (305) 377-5385

INTERNET ACCESS TO THE DIVISION OF WORKERS' COMPENSATION

http://www.fdles.state.fl.us/wc/

NEW YORK WORKERS COMPENSATION
OCTOBER 1, 2010 LOSS COST REVISION
EXPLANATORY MEMORANDUM

This is your notification that the premiums for the period of coverage commencing on or after October 1, 2010 are provisional and may be subject to upward or downward adjustment, retroactive to the effective date of the policy. You may be required to pay an additional premium, or be entitled to a credit, if it is determined that an adjustment is necessary to meet statutory rating standards. Since each carrier applies its approved loss cost multiplier to the published loss costs when developing final rates, the percentage changes shown in this memorandum may not necessarily be indicative of your October 1, 2010 rates.

Changes in Loss Costs – An overall loss cost level increase of 7.7%, which includes an increase of 7.9% in the average manual loss cost level and no change in the loss costs for terrorism and natural disasters and catastrophic industrial accidents, has been approved by the New York State Insurance Department to become effective on October 1, 2010.

Loss Experience – The New York Compensation Insurance Rating Board has determined that the latest two policy years of experience produced a 2.9% increase in the overall loss cost level.

Legislative Changes – This revision includes an estimate of the latest cost of the increases in the maximum weekly benefits that were set forth in the 2007 workers compensation reform legislation. The overall impact of the benefit changes that were quantified in the loss cost revision is an increase of 4.5% in manual loss costs.

Future Trends – The latest analysis of New York claim severity and claim frequency indicates a continuing decrease in claim frequency and an upward trend in claim costs. Combined with a modest increase in overall wage trends, as well as consideration of potential savings as a result of the anticipated implementation of the Medical Treatment Guidelines on a mandatory basis, a 0% net trend factor was approved.

Catastrophe Provision – This revision contains no changes in the loss cost for terrorism and in the loss cost for natural disasters and catastrophic industrial accidents.

Classification Loss Costs – Although the average manual loss cost level is increasing by 7.9%, 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.

WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide by same for 90 days.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of the services rendered if such services are determined to have been unreasonable or unnecessary.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

WORKERS' COMPENSATION
EMPLOYEE NOTIFICATION
Part 2

Workers' Compensation Information

(1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

(2) Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

Employee signature _____ **Date** _____

POLICYHOLDER INFORMATION NOTICE

To Our Florida Policyholders:

If you have a question about your insurance policy, you may contact your agent or broker, or call us directly by using our toll-free number.

CHUBB INDEMNITY INSURANCE COMPANY 1-800-884-4669

workers' compensation

reporting injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

occupational disease or death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1. the disease manifests itself.
2. the employee is disabled as a result of the disease.
3. the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1. the date of death.
2. the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

filing notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

formal claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of benefits.

information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

CHUBB INDEMNITY INSURANCE COMPANY
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

_____

_____

_____

_____

Employer

PAMLAB INC.

P.O. BOX 8950
MANDEVILLE
LA
70470

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business. Revised 05-03

LOUISIANA WORKS
DEPARTMENT OF LABOR

www.LAWORKS.net

08 10 0517 (Ed. 5/03)

TEXAS COMPLAINT NOTICE

Should any dispute arise about your premiums or about a claim that you have filed, contact the agent or write to the company that issued the policy. If the problem is not resolved, you may also write the Texas Department of Insurance, Consumer Protection (111-1A), PO Box 149091, Austin, TX 78714-9091. This notice of complaint procedure is for information only and does not become a part or condition of this policy.

CHUBB

IMPORTANT NOTICE

OKLAHOMA WORKERS' COMPENSATION POLICYHOLDERS

In compliance with Oklahoma Insurance Laws Title 36 section 6701 our workplace safety services, which meet the standards of the law, are available to you upon request. As your workers' compensation insurance carrier, we can provide appropriate services based upon the nature of your operations. Such services are also available from the Oklahoma State Insurance Fund.

If you would like more information call 1-877-248-2202 or email *loss_control_service@chubb.com.* If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

CHUBB

IMPORTANT NOTICE

OREGON WORKERS COMPENSATION POLICYHOLDERS

AVAILABLE LOSS PREVENTION SERVICES

The Chubb Group of Insurance Companies is required by section 437-001-1025 of the Oregon Administrative Rules of the Oregon Occupational Safety and Health Division to notify our workers compensation policyholders with Oregon employees of available loss prevention services. The State of Oregon under the Oregon Safe Employment Act (ORS 654.001 § 654.295 and 654.991) makes employers responsible to provide a safe and healthful workplace. Our Loss Control Department can provide the required and appropriate services to assist Oregon policyholders meet their safety and health responsibilities. The following services are available upon request for your Oregon operations:

- Evaluation of your loss prevention needs.
- Assistance in evaluating injury and illness records to determine the loss experience and trends.
- An explanation of the Oregon Safe Employment Act and rules that apply to your particular place of employment.
- Provision of partial or complete on-site health and safety surveys, which identify all reasonably discoverable occupational safety and health hazards within the scope of the survey scheduled.
- Assistance with industrial hygiene and safety evaluations to detect physical and chemical hazards of the workplace, and implementation of engineering or administrative controls.
- Assistance with evaluating, obtaining, and maintaining personal protective equipment.
- Evaluation of work practices, workplace design, and assistance with job site modifications related to injury and illness prevention.
- Assistance in evaluation and improving your safety management practices.
- Assistance in identifying health and safety training needs and available resources.
- The provision of follow up services as appropriate.

If you would like more information call 1-877-248-2202 or email *loss_control_service@chubb.com.* If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

As the insurance responsible person for your company, we ask that you forward this notice to your main Oregon office and each fixed place of employment in Oregon.

Should we fail to respond to your request for loss prevention services or otherwise fail to provide services as offered or required, you may file a complaint with the OR- OSHA Division.

CHUBB

IMPORTANT NOTICE TO POLICYHOLDERS – TEXAS

Chubb Group of Insurance Companies are required by law to provide its policyholders with certain accident prevention services as required by the Texas Labor Code, §411.066, at no additional charge and return-to-work coordination services* as required by Texas Labor Code §413.021.

*** Return-to-work coordination services are provided by Chubb Claims. Such services should be requested by calling 1-800-873-0777 ext. 8103 and speaking with a Workers Compensation Claim representative.**

If you would like more information for loss control services call Chubb at 1-877-248-2202 or email *loss_control_service@chubb.com*. If you leave a message or send an email inquiry, please include your name, phone number, company name, email address, workers compensation policy number and a brief description of the loss control services being requested.

If you have any questions about this requirement, call the Division of Workers' Health and Safety, Texas Workers' Compensation Commission at 1-800-687-7080.

CHUBB

NEW YORK WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

New York law permits us to offer deductibles for medical and/or indemnity expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY issued by a member company of the Chubb Group of Insurance Companies. Any deductible you select will apply separately to each compensable occurrence.

If you select a deductible, your Workers' Compensation premium will be reduced by the appropriate premium percentage reduction under the hazard group classifications shown below. Your hazard group classification is E . For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your New York operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place an "x" next to the deductible you want and return the signed, completed form to Chubb or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective at the subsequent anniversary of your existing policy.

Percentage Premium Reduction by Hazard Group

	Deductible	A	B	C	D	E	F	G
_____	$ 100	0.1	0.1	0.1	0.1	0.1	0.1	0.1
_____	$ 200	0.2	0.2	0.2	0.1	0.1	0.1	0.1
_____	$ 300	0.4	0.3	0.2	0.2	0.2	0.2	0.1
_____	$ 400	0.4	0.4	0.3	0.3	0.2	0.2	0.2
_____	$ 500	0.5	0.5	0.4	0.4	0.3	0.2	0.2
_____	$1,000	1.0	0.9	0.7	0.7	0.6	0.5	0.4
_____	$1,500	1.5	1.3	1.0	0.9	0.8	0.7	0.6
_____	$2,000	1.9	1.7	1.3	1.2	1.1	0.8	0.7
_____	$2,500	2.3	2.0	1.6	1.4	1.3	1.0	0.9
_____	$5,000	4.0	3.6	2.9	2.6	2.4	1.8	1.7

Signed: _____ Date: _____

Authorized Representative
of Named Insured

Named Insured: PAMLAB INC.

Named Insured's Mailing Address P.O. BOX 8950
MANDEVILLE LA 70470

Binder/Policy Number: (13)7575-25-17

Name and Address of Agent: STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471

CHUBB GROUP OF INSURANCE COMPANIES

Dear Policyholder:

Texas recently enacted workers compensation reform legislation that allows the employer/insurance carrier to direct care of injured employees to a Health Care Network (HCN), effective January 1, 2005.

As you know, Chubb selected CorVel's CorCare network to provide medical treatment for all work-related injuries in Texas. A Chubb business partner for several years, CorVel has been a certified Health Care Organization in Texas since July 18, 2006 and one of the first four networks to become certified under the new legislation.

Any insured who is interested in participating in the HCN will be entitled to a 5% premium credit and must have a HCN endorsement to their policy. The final state approved Employee Notification Kit from CorVel with pertinent information on enrolling employees in the HCN is available on **Chubb.com** in its entirety. This kit must be given to employees prior to implementing the HCN. Please be advised that notification to all employees must be both English and Spanish.

At Chubb, we believe that timely, quality medical care and early reporting of a claim is the best approach to containing your workers compensation costs. Participation in the Health Care Network will help support medical cost containment and facilitate prompt return to work.

To find a medical center in the HCN, follow these steps:

- Go to http://www.corvel.com
- Click "PROVIDER LOOK-UP"
- Click "Find Providers Near You"
- Select "CorCare (Texas-HCN) and click "Continue"
- Enter your zip code and click "Continue"
- Under "3) HOSPITAL OR FACILITY SEARCH", choose "Occupational Medical Center" in the drop-down menus, then click "Continue"

This will provide you a list of medical clinics in your area that are part of the HCN.

Thank you for your cooperation.

Chubb Group of Insurance Companies
Warren, New Jersey 07059

CHUBB

VIRGINIA

APPLICATION FOR DRUG FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Address of Employer: _____

Date Program Implemented: _____

Please attach a copy of employer's written substance abuse policy

Education:

_____ Supervisory training How long _____

_____ Employee education How long _____

_____ Employee Assistance Program or Community health services directory

Name and address of Employee Assistance Program: _____ Phone #: _____

Notice of Employer's Drug Testing Policy:

_____ Copy to all employees prior to testing

_____ Posted on employer's premise

_____ Copy to job applicant

_____ Show notice of drug testing on vacancy announcements

_____ Copies available in personnel office or other suitable locations.

Testing:

Drug Testing has been conducted in the following area: (check all that apply)

_____ Job applications

_____ Reasonable suspicion

_____ Post Accident

_____ Random testing

_____ Follow-up to Employee Assistance Program/Rehabilitation

Name and address of Medical Review Officer: _____

_____ Phone # _____

Name and address of DHHS certified lab: _____

_____ Phone # _____

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

THE ABOVE SIGNED CERTIFIES THAT THIS INFORMATION IS A TRUE AND FACTUAL DEPICTION OF THEIR CURRENT PROGRAM

_____	_____	_____
Notary Public's Signature	Date	Expiration of Commission

This application is to be completed, signed, notarized, and returned to your agent or broker, who will forward it to the carrier as proof of the existence of a certified program.

SOUTH CAROLINA
APPLICATION FOR DRUG AND ALCOHOL FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

This form must be completed by you and returned to the your carrier with a copy of applicable documentation as proof of compliance before the premium credit of five percent (5%) can be established and processed. **A program must be certified during each year the employer receives credit**. Failure to do so will remove you from eligibility for this credit.

The following are the four (4) minimum requirements necessary for a qualified employer workplace program. Please check the items below that apply.

( ) 1) **Substance Abuse Policy Statement:**
Any policy must be designed to help employees who need substance abuse assistance while, at the same time, sending a clear message that the abuse of drugs and alcohol is not compatible with employment in that employer's workplace. The policy statement must evidence both the employer's respect for its employees and the employer's need to maintain a safe, productive, substance-abuse-free environment.

( ) 2) **Employee Notification:**
In order to protect the individual rights of each employee and to begin the employee education process necessary for a well-defined, well-managed workplace drug and alcohol abuse prevention program, each existing employee and each new employee hired after program implementation must be given a clear, concise, readable notice of the program, the program's requirements, the policy statement, and the employer's expectations under the program. Notification should be, and should remain, posted in employee common areas. In addition, each existing employee and each new employee must be given, by mail or by in-person delivery, a copy of the notice. Delivery may be accomplished by inclusion of the notice within the employee's paycheck package or any similarly important-to-the-employee correspondence or benefits delivery.

( ) 3) **Testing Procedure:**
The testing procedure must include a provision for random sampling of all persons who receive wages and compensation in any form from the employer and must provide for a second test to be administered within thirty minutes of the administration of the first test. Positive test results must be provided in writing to the employee within twenty-four hours of the time the employer receives the test results. Each employer must keep records of each test for up to one year.

( ) 4) **Test Results Confidentially Protocols:**
Test results, information, interviews, reports, statements, and memorandums received by the employer must be considered confidential and may not be used, received, or discovered in civil, criminal, or administrative proceedings. The burden to protect against unauthorized release is placed not only upon the employer and any laboratory, medical review officer, or rehabilitation program or their agents, but also upon the underwriting insurer. Employers, laboratories, medical review officers, insurers, drug or alcohol rehabilitation programs, and employer drug prevention programs, and their agents who receive or have access to information concerning test results shall keep all information confidential. Release of such information under any other circumstance shall be solely pursuant to a written consent form signed voluntarily by the employee tested or his designee unless the release is completed through disclosure by an agency of the State in a civil or administrative proceeding, order of a court of competent jurisdiction, or determination of a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain at a minimum:

(1) the name of the person who is authorized to obtain the information;
(2) the purpose of the disclosure;
(3) the precise information to be disclosed;
(4) the duration of the consent; and
(5) the signature of a person authorizing release of the information.

Information on test results shall not be released for or used or admissible in any criminal proceeding against the employee.

I certify that the above information is accurate and that I may be subject to an additional premium charge if it is determined that there is any misrepresentation of the established drug and alcohol free workplace program criteria. This is a true and factual depiction of my current program.

Employer Name	Date	Officer/Owner Signature*

*Application must be signed by an officer or owner

Title

Notary Public's Signature	Date	Exp. of Commission

Form 08-10-0422 (Ed. 10-97)

WC 21 03 03 A

MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

This endorsement applies only to the insurance provided by the policy because Michigan 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 us or your agent.

   You may obtain pertinent rating information by submitting a written request to us at our 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 rates and premiums were determined. If you are not satisfied with the results of the review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Payroll Audits

   You may request a payroll audit once each calendar year. Your request must be in writing, sent to our address shown in this endorsement. You must state that you believe your payroll expenditures have changed by 20% or more, and you must state the reasons for that belief. We will complete the audit within 120 days of receipt of your request if you provide us with all information we need to perform the audit.

3. Reserves or Redemption

   You may request reserve and redemption information that relates to the premium for this policy. Your request must be in writing sent to our address shown in this endorsement. We will provide you with that information within thirty (30) days of receipt of your request.

   If you believe that the policy premiums are excessive because we set unreasonable reserves or because of the unreasonable redemption of a claim, you may request a meeting with our management representative. Your request must be in writing sent to our address shown in this endorsement. If you are not satisfied with the results of the meeting, you may appeal to the Insurance Commissioner at the address shown in this endorsement.

Addresses

Commissioner of Insurance
Michigan Insurance Bureau
P.O. Box 30220
Lansing, MI 48909

Company Address
Chubb Group of Insurance Companies
15 Mountain View Road
P.O. Box 1615
Warren, NJ 07061-9981

CHUBB

NOTIFICATION OF AVAILABLE LOSS CONTROL CONSULTATION SERVICES

CALIFORNIA WORKERS COMPENSATION

The Chubb Group of Insurance Companies maintains and provides Loss Control Services as required by California law. These services may be provided to our insured workers compensation policyholder places of employment. Chubb is committed to helping our workers compensation policyholders provide for safe and healthy workplaces for their California employees through the provision of loss control services appropriate to the individual business.

Available services that may be provided if requested include:

- A workplace survey to identify safety and health hazards and their control.
- A review of workers compensation injury records to identify accident trends and their causes.
- Assistance in the development of your loss control management plan to minimize workplace injuries. This includes a review of your 8 CCR, Sec. 3203 employer's Injury and Illness Prevention Program (IIPP).

As appropriate, written findings and recommendations will be made that address uncontrolled hazards and program deficiencies including your employer's Injury and Illness Prevention Program.

The above services are available at no additional charge to Chubb workers compensation policyholders for their covered California employees.

To request such services, call 1-877-248-2202 (toll free) or submit your request by email directed to the following address: *loss_control_service@chubb.com*. IMPORTANT: When leaving a message or sending email, please provide your name, phone number, company name and the nature of your request.

The Chubb Group of Insurance Companies maintains and provides the following additional loss control services for our policyholders as part of a Chubb Loss Control Service Program.

Safety Management Training
Employee Safety Training
Safety Program Audits
Industrial Hygiene Service
Ergonomic Program Assessment
Accident Investigation Training
Specific Hazard Assessments
Accident Analysis

Workers' compensation insurance policyholders may direct questions or complaints about the insurers loss control consultation services by contacting: State of California, Department of Industrial Relations, Loss Control Services Coordinator, The Commission on Health, Safety & Workers' Compensation, 455 Golden Gate Avenue, 10th Floor, San Francisco, CA 94102, phone (415) 703-4220.

CHUBB

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 might 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 Acts of 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 Section 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.

POLICYHOLDER NOTICE

YOUR RIGHT TO RATING AND DIVIDEND INFORMATION

I. Information Available to You

A. Information Available from Us - CHUBB INDEMNITY INSURANCE COMPANY

(1) General questions regarding your policy should be directed to 2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

(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). Contact information for the WCIRB is: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. You may also contact WCIRB Customer Service at 1-888-229-2472, by fax at 415-778-7272, or via the Internet at the WCIRB's website: http://www.wcirbonline.org. The regulations contained in the USRP and the ERP are available for public viewing through the WCIRB's website.

(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, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Custodian of Records. The Custodian of Records can be reached by telephone at 415-777-0777 and by fax at 415-778-7272.

(3) **Experience Rating Form.** Each experience rated risk may receive a single copy of its current Experience Rating Form free of charge by completing a Policyholder Rate Sheet Request Form on the WCIRB's website at https://wcirbonline.org/ratesheet. The Experience Rating Form 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:

801 South Figueroa St.
Los Angeles, CA 90017
1-800-36CHUBB

After you send your Complaint and Request for Action, we have 30 days to send you a written notice indicating whether or not 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 14 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Customer Service. Customer Service can be reached by telephone at 1-888-229-2472, and by fax at 415-778-7272.

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 or not 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, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Complaints and Reconsiderations. The WCIRB's telephone number is 1-888-229-2472, and the fax number is 415-371-5204.

C. California Department of Insurance – Appeals to the Insurance Commissioner. If, after you follow the appropriate dispute resolution process described above, we or the WCIRB decline to review your request, if you are dissatisfied with the decision upon review, or if 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 the WCIRB. The filing address for all appeals to the insurance commissioner is:

Administrative Hearing Bureau
California Department of Insurance
45 Fremont Street, 22nd Floor
San Francisco, California 94105

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, 525 Market Street, Suite 800, San Francisco, California 94105-2767, Attention: Policyholder Ombudsman. The policyholder ombudsman can be reached by telephone at 415-778-7159 and by fax at 415-371-5288.

B. California Department of Insurance – Information and Assistance. Information and assistance on policy questions can be obtained from the Department of Insurance Consumer HOTLINE, 1-800-927-HELP (4357) or http://www.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.

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POLICYHOLDER NOTICE

CALIFORNIA INSURANCE GUARANTEE ASSOCIATION (CIGA) SURCHARGE

Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent, the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, "CA Surcharge" or "CA Surcharge (CIGA Surcharge)" with an amount will be displayed on your premium notice.

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

08 10 0468 (Ed. 12-01)
DN 04 99 04

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ERM-14 FORM—CONFIDENTIAL REQUEST FOR OWNERSHIP INFORMATION

Effective 01 Dec 2003

All items must be answered completely or the form may be returned.

The following confidential ownership statements may be used only in establishing premiums for your insurance coverages. Your workers compensation policy requires that you report ownership changes, and other changes as detailed below, to your insurance carrier in writing within 90 days of the change. If you have questions, contact your agent, insurance company, or the appropriate rating organization. Once completed, this form must be submitted to the rating organization by you, your insurance carrier(s), or your agents. If this form does not provide the means to explain the transaction, enter as much information on the form as possible and supplement the form with a narrative on the employer's letterhead, signed by an owner, partner, or executive officer.

Section A—Transaction and Entity Information

Check all that apply	Type of Transaction Columns A, B, and C referenced below are found in Section B.	Effective Date Enter effective date of transaction	Reported Date Enter date reported in writing to your insurance provider
	Name and/or legal entity change—Complete column A for former entity and column B for newly named entity. Complete Type of Entity portion for each entity to reflect such change.		
	Sale, transfer or conveyance of all or a portion of an entity's ownership interest—Complete column A for ownership before the change and column B for ownership after the change.		
	Sale, transfer or conveyance of an entity's physical assets to another entity that takes over its operations—Complete column A for the former entity and column B for the acquiring entity.		
	Merger or consolidation (attach copy of agreement)—Complete columns A and B for the former entities and column C for the surviving entity.		
	Formation of a new entity that acts as, or in effect is, a successor to another entity that: (a) Has dissolved (b) Is non-operative (c) May continue to operate in a limited capacity.		
	An irrevocable trust or receiver, established either voluntarily or by court mandate—Complete column A before the change and column B after the change.		
	Determination of combinability of separate entities—Complete a separate column in Section B for each entity to be reviewed for common ownership (attach additional forms if necessary).		

ENTITY 1—Complete Column A on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ FEIN _____

Type of Entity (check all that apply) Carrier _____ Policy # _____ Eff. Date _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Location(s) _____

ENTITY 2—Complete Column B on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ FEIN _____

Type of Entity (check all that apply) Carrier _____ Policy # _____ Eff. Date _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Location(s) _____

ENTITY 3—Complete Column C on Page 3

Complete Name of Entity (including DBA or TA) _____

Risk ID _____ FEIN _____

Type of Entity (check all that apply) Carrier _____ Policy # _____ Eff. Date _____

☐ Sole Proprietorship	☐ Limited Partnership	☐ Temporary Labor Service	☐ School District	☐ Irrevocable Trust
☐ Partnership	☐ Limited Liability Corporation	☐ Publicly Traded	☐ For Profit	☐ Religious Organization
☐ Domestic Corporation	☐ Joint Venture	☐ State Agency	☐ Not for Profit	☐ Charitable Organization
☐ Foreign Corporation	☐ Association (including unincorporated)	☐ County Agency	☐ Non-Profit	☐ Franchise
☐ Sub-Chapter S-Corp	☐ Employee Leasing	☐ Municipality	☐ Revocable Trust	☐ ESOP

Primary Address

Street _____ City, State, Zip _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Contact Name _____ Web Site _____

Mailing Address (if different than Primary Address) _____

Additional Location(s) _____

Section B—Ownership

1. Have any of these entities operated under another name in the last four years? ☐ Yes ☐ No
2. Are any of the entities **currently** related through common majority ownership to any entity not listed on the front of the form? ☐ Yes ☐ No
3. Have any of these entities been **previously** related through common majority ownership to any other entities in the last four years?
   ☐ Yes ☐ No
4. If you answered Yes to questions 1, 2, or 3 above, provide additional information, indicating which question(s) your answer references:
   ☐ 1 ☐ 2 ☐ 3

Name of Business	Principal Location	Carrier and Policy Number	Effective Date

5. Were the assets and/or ownership interest (all or a portion) of this entity acquired from a previously existing business? ☐ Yes ☐ No
   If yes, you must provide complete ownership information for the prior owner in column A and ownership information for the new owner in column B.
6. If this is a partial sale, transfer, or conveyance of an existing business (i.e., sale of one or more plants or locations):
   a. Explain what portion or location of the entire operation was sold, transferred, or conveyed.

   _____

   b. Was this entity insured under a separate policy from the remaining portion? ☐ Yes ☐ No
   If not, specify the entities with which it was combined:

   _____

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7. Did the legal status of this entity change? ☐ Yes ☐ No
   If yes, you must complete the Type of Entity portion for each entity to reflect such change.
8. Is this transaction a result of bankruptcy? ☐ Yes ☐ No
   If yes, please indicate under which Chapter the bankruptcy was filed. _____

Corporations—List all names of owners of 5% or more of voting stock and number of shares owned. Submit shareholder proposal if transaction involved exchange of stock.

Partnerships—List each partner and appropriate share in the profits. If the entity is a limited partnership, list name(s) of each general partner(s).

Other—If no voting stock, list members of board of directors or comparable governing body.

Information	Column A	Column B	Column C
	Enter name used in Section A for Entity 1 **Entity 1**	Enter name used in Section A for Entity 2 **Entity 2**	Enter name used in Section A for Entity 3 **Entity 3** If applicable, use this column for multiple combinations or entities resulting from mergers and consolidations
Name of Entity			
Ownership See reference above to ownership information required for corporations, partnerships, and other entities.			
Total Ownership Interest or Number of Shares			

NOTE: If your business has changed significantly to result in a change to the primary (governing) classification and the process and hazard of the operation have also changed, contact your agent, insurance company or rating organization for additional information.

Section C—Additional Information

Please include any additional information you believe pertinent to the transaction detailed above that cannot be expressed due to the format of this form. If there is not enough space below, attach the information on the entity's letterhead, signed by an owner, partner, or executive officer.

_____

_____

_____

_____

_____

Section D—Did You Remember to . . .

- Indicate the type of transaction, check all that apply, and include transaction and notification dates?
- Complete all necessary entity information? **Note:** You can use more forms if the number of entities exceeds three.
  - Entity name
  - Risk identification number (if you know it)
  - Federal Employer Identification Number (FEIN)
  - Type of entity
  - Primary address, telephone, and other contact information
  - Mailing address and additional locations if applicable
- Fill out the ownership table completely?
  - Include the names of the entities as listed in Section A?
  - Include all owners, partners, board of director members, members and/or manager of LLCs, general partners of LPs, or any other comparable governing body?
  - Include percentage of ownership for each owner, partner, board of director member, member and/or manager of LLCs, general partner of LPs, or any other comparable governing body?
- Answer questions 1 through 8?

Section E—Certification

This is to certify that the information contained on this form is complete and correct.

All forms will be returned if this Certification Section is incomplete.

Name of person completing form: _____

Check which entity or entities the signer represents: ☐ Entity 1 ☐ Entity 2 ☐ Entity 3 ☐ Other _____

Signature of Owner, Partner, Member, or Executive Officer	Title	Carrier
Print name of above signature	Date	Carrier Address

Section F—For Rating Organization Use Only

Associate/automated _____

Date received _____

Date complete _____

Assessment—form complete? What is missing? _____

Ruling _____

Revisions necessary—Yes/No _____

Revisions complete and mailed—Yes/No/NA _____

Rating Effective Date impacted—Yes/No—if Yes, which ones? _____

Risk ID impacted—list all impacted, any deactivated? Indicate deactivated #s _____

All carriers/rating organizations notified? _____

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COLORADO WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

Colorado law requires that we provide a notice outlining the available deductibles for medical expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY issued by a member company of the Chubb Group of Insurance Companies. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced based on the deductible amount selected and a credit amount determined by Chubb. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your Colorado operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place and "x" next to the deductible you want and return the signed, completed form to Chubb or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective the date we receive the form in our office.

	Deductible Amount
_____	$ 500
_____	$1,000
_____	$1,500
_____	$2,000
_____	$2,500
_____	$5,000

Signed: _____ Date: _____

Authorized Representative
of Named Insured

Named Insured: PAMLAB INC.

Named Insured's Mailing Address P.O. BOX 8950
MANDEVILLE LA 70470

Binder/Policy Number: (13)7575-25-17

Name and Address of Agent: STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471

CHUBB

OKLAHOMA WORKERS' COMPENSATION MEDICAL DEDUCTIBLE ACCEPTANCE/REJECTION FORM

Oklahoma law requires insurers to offer a medical claims deductible on all Oklahoma Workers' Compensation policies. Five medical deductible options are available. You are not required to select the medical deductible option, but if you choose to exercise this option, you may choose only one deductible amount. Please carefully review the requirements for the medical deductible option outlined below.

MEDICAL DEDUCTIBLE OPTIONS

The medical claims deductible options are five hundred dollars ($500), one thousand dollars ($1,000), one thousand five hundred dollars ($1,500), two thousand dollars ($2,000), and two thousand five hundred dollars ($2,500). If you choose one of these options, you will be liable for the amount of the deductible for the medical benefits paid on **every claim** for bodily injury by accident or disease filed by an injured employee. Claim amounts up to five hundred dollars ($500) annually which are paid under the deductible will be excluded from your experience modifier.

EMPLOYER OBLIGATIONS IF MEDICAL DEDUCTIBLE OPTION IS SELECTED

Oklahoma law prohibits you from directly or indirectly charging to or passing on the medical deductible amount to the injured worker or the insurer.

If you choose a medical deductible option, the insurer will pay the entire cost of medical bills directly to the provider of the services and then seek reimbursement from you for the deductible amount. The insurer will bill you for the deductible amount. **WARNING: You must reimburse the insurer within sixty days of a written demand. If you fail to reimburse the insurer within sixty days, the insurer may seek to recover the full amount of such claim from you.**

ACCEPTANCE/REJECTION

☐ Yes, I have read the medical deductible information outlined above and want the following medical deductible amount to apply to medical claims under Oklahoma Workers' Compensation Law. I understand that this medical deductible applies to **every claim** for bodily injury by accident or disease filed by an injured employee.

- ☐ $ 500
- ☐ $1,000
- ☐ $1,500
- ☐ $2,000
- ☐ $2,500

☐ No, I do not want the medical deductible described in this notice.

NAMED INSURED: PAMLAB INC.

ADDRESS: P.O. BOX 8950
MANDEVILLE LA 70470

TITLE: _____

SIGNATURE: _____

DATE: _____

THIS FORM IS NOT A PART OF YOUR POLICY AND DOES NOT PROVIDE COVERAGE.

Form 35-3 B (Ed. 6-97)
Form 08-10-0359 (Ed. 6-97)

CHUBB

IMPORTANT NOTICE TO POLICYHOLDERS

This Important Notice is not your policy. Please read your policy carefully to determine your rights, duties, and what is and what is not covered. Only the provisions of your policy determine the scope of your insurance protection.

THIS IMPORTANT NOTICE PROVIDES INFORMATION CONCERNING POSSIBLE IMPACT ON YOUR INSURANCE COVERAGE DUE TO COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS.

PLEASE READ THIS NOTICE CAREFULLY.

Various trade or economic sanctions and other laws or regulations prohibit us from providing insurance in certain circumstances. For example, the United States Treasury Department's Office of Foreign Asset Control (OFAC) administers and enforces economic and trade sanctions and places restrictions on transactions with foreign agents, front organizations, terrorists, terrorists organizations, and narcotic traffickers. OFAC acts pursuant to Executive Orders of the President of the United States and specific legislation, to impose controls on transactions and freeze foreign assets under United States jurisdiction. (To learn more about OFAC, please refer to the United States Treasury's web site at http://www.treas.gov/ofac.)

To the extent that you or any other insured, or any person or entity claiming the benefits of this insurance has violated any applicable sanction laws, this insurance will not apply. We have added a condition or section that applies to the entire policy called Compliance With Applicable Trade Sanctions, which stipulates that your insurance policy does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY FORM PP-1B

NEW JERSEY
NOTICE OF ELECTION - PROPRIETORS AND PARTNERS
WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

The New Jersey Workers' Compensation Law was amended effective April 13, 2000. The amendment permits **election** by a self-employed person or partners of any partnership including partners of a limited liability partnership and members of a limited liability company actively performing services on behalf of the business to be deemed employees for the purpose of receipt of benefits and the payment of premiums. This election does not affect the insurance obligations for employees other than the self-employed person, partners or members.

The election must be made at the time the policy is purchased or renewed and must be effective at the inception date of the policy. It is important to note that the election cannot be rescinded during the policy period and that in the case of any partnership including a limited liability partnership or limited liability company, **ALL** of the partners or **ALL** of the members must elect the coverage. You will be required to pay a premium based on the remuneration and duties of the self-employed person or each partner or each member.

The insurer or insurance producer shall not be liable in an action for damages on account of the failure of a business, limited liability partnership, limited liability company or partnership to elect to obtain workers' compensation coverage for a self-employed person, limited liability partner, limited liability company member or partner, unless the insurer or insurance producer causes damage by a willful, wanton or grossly negligent act of commission or omission.

Whether electing or rejecting coverage, it will be necessary to complete all of the information requested below. This completed form must then be returned to the insurer/producer. A copy of this Notice and proof of mailing should be retained for your records. If you received this form in relation to a renewal of insurance, and fail to execute and return it to the insurer/producer, coverage will continue as per the expiring policy.

NAME OF BUSINESS _____

COVERAGE IS ELECTED ___ **COVERAGE IS REJECTED** ___ **BUSINESS IS A CORPORATION OR OTHER FORM OF ORGANIZATION** ___

Always complete this section

Name(s) of Proprietor or ALL Partners (please print)	Estimated Annual Wage	Duties
1.		
2.		
3.		
4.		
5.		
6.		

Complete this section only when coverage is elected

Signature: _____ Date: _____
Proprietor or a Partner

Always complete this section

ATTENTION

EMPLOYERS ARE REQUIRED TO PROVIDE THIS FORM TO EACH INJURED WORKER

OMBUDSMAN/CLAIMS ADVISORY
DIVISION OF WORKERS COMPENSATION
KANSAS DEPARTMENT OF LABOR
800 SW JACKSON STREET STE 600
TOPEKA KS 66612-1227

TOLL FREE 1-800-332-0353

If you were hurt on the job and have any questions about Workers Compensation benefits contact the **Ombudsman/Claims Advisory Section** at the Kansas Division of Workers Compensation. The Division of Workers Compensation has full-time personnel who specialize in aiding injured workers with claim information and problems. They can give information about benefits an injured worker may be entitled to receive. They can help try to solve problems with benefits not being paid on time, with medical treatment, with unpaid medical bills, with questions about how to figure settlement amounts, etc. Assistance in Spanish is available at the Division of Workers Compensation.

WHAT TO DO IF AN ACCIDENT OCCURS ON THE JOB:

1. Tell your employer that you were hurt on the job.

2. Follow your employer's instructions on getting medical aid and follow the doctor's instructions.

3. Within 200 days of the date of accident or the date of last payment of compensation for disability or authorized medical care, tell your employer **in writing** that you expect workers compensation benefits for your injury. Your employer might know you were hurt and compensation may be paid, however, you could lose all rights to future compensation if you do not tell the employer **in writing**. This is called a **"Written Claim."** Written claim may be served in person by taking it to the employer and getting a receipt for it or by mailing it to the employer by certified mail, return receipt requested. The post office receipt for the certified letter is generally sufficient proof that you sent written claim.

AVERAGE WEEKLY WAGE: A worker's "average weekly wage" is calculated by adding together the **base wage**, the **average weekly overtime** and the **weekly value of fringe benefits** that have been discontinued.

WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self-insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 ⅔ percent of his average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas compensation law provides for additional benefits.

MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

RESPONSIBILITIES OF THE EMPLOYER:

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits regardless of insurance coverage.

5. Upon receiving notice of an injury, employers must provide the employee with written information to assist the injured worker in understanding their rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS:

YOUR CLAIM WILL BE HANDLED BY:

Company CHUBB INDEMNITY INSURANCE COMPANY

Address 2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Contact Person _____

Telephone _____

ATENCIÓN

Los Empleadores Son Requeridos a Proporcionar esta forma a cada Trabajador Lesionado

Llamada Gratis 1-800-332-0353
Consultores de Reclamos/Ombudsman

O Escriba A:
DIVISION OF WORKERS COMPENSATION
800 SW JACKSON STREET, SUITE 600
TOPEKA, KS 66612-1227

Si usted se ha lastimado en su trabajo, y tiene preguntas con respecto a los beneficios de la Compensación de Trabajadores, comuníquese con la **SECCIÓN DE CONSULTIVOS DE RECLAMOS/OMBUDSMAN** de la División de Compensación Para Trabajadores de Kansas. Esta División mantiene personal especializado en proveer asistencia con problemas de reclamos y en dar información sobre estos a los trabajadores lastimados. Este personal le puede informar sobre los beneficios que un trabajador lastimado tiene derecho a recibir. También pueden asistirle en resolver los problemas con respecto a los beneficios que no se le están pagando a tiempo, al tratamiento médico, facturas de doctores que aún no se han pagado, y también con preguntas respecto a la cantidad del arreglo (settlement). En la División de Compensación de Trabajadores hay asistencia disponible en Español.

¿QUE HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

1. Avísele inmediatamente al empleador que usted se ha lastimado en su trabajo. **Dentro de 10 dias del accidente.**

2. Siga las instrucciónes del empleador con respecto al tratamiento médíco, y siga las instrucciónes del doctor.

3. Dentro de 200 días del accidente, o del último día en que le pagaron compensación por estar incapacitado, o en que recibió tratamiento médico autorizado, avísele al empleador **POR ESCRITO** que usted espera recibir los beneficios de compensacion de trabajadores, por su accidente. Aunque su empleador ya se haya informado del accidente, y ya le esté pagando los beneficios, usted puede perder el derecho de recibir compensación en el futuro, si no le avisa al empleador **POR ESCRITO**. Esta documentación es lo que se llama **AVISO POR ESCRITO (WRITTEN CLAIM)**. El Aviso Por Escrito se puede entregar al empleador de dos maneras diferentes: Se lo puede entregar en persona, y al mismo tiempo que se lo entrega, pídale un recibo. También se lo puede enviar por correo certificado, y el recibo será su prueba de que envió el Aviso Por Escrito.

PROMEDIO DEL SUELDO SEMANAL: Se calcula sumando lo siguiente: el sueldo básico, más un promedio de horas extras trabajadas por semana, mas el valor semanal de cualquier beneficio adicional que haya sido descontinuado.

BENEFICIOS SEMANALES: Los Beneficios se los paga la compañiá aseguradora del empleador, o el programa interno de seguros del empleador. El trabajador lastimado no recibe compensación por la primera semana que este sin trabajar, **A MENOS QUE** esté sin trabajar por orden del doctor durante tres semanas consecutivas. El primer pago de compensación normalmente se le debe al trabajador al terminar el catorceavo día de estar sin trabajar. Un trabajador lastimado a causa del trabajo tiene derecho casa semana a una cantidad equivalente al 66 2/3% porciento del promedio de su sueldo semanal, hasta llegar a un máximo equivalente al 75% porciento del promedio de sueldos semanales designado por el Estado de Kansas. Estos beneficios son sujetos a cualquier cambio que ordene la legislatura del estado. Si el accidente resulta en una incapacidad permanente, la ley de compensación en Kansas le da derecho a otros beneficios adicionales.

BENEFICIOS MEDICOS: Un trabajador lastimado tiene derecho a todo servicio médico razonable y necesario para curar y aliviarle de los efectos del accidente. El empleador, tiene derecho a escojer el doctor para dar el tratamiento médico necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite máximo de $500.00 dólares. El trabajador puede pedirle al Director de la Division de Compensación de Trabajadores el cambio de el doctor autorizado. Los gatos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean establecidos por la ley, siempre y cuando sean más de (5) cinco millas viaje redondo.

RESPONSABILIDADES DEL EMPLEADOR:

1. El empleador debe reportar cada accidente de los trabajadores a la División de Compensación de Trabajadores dentro de 28 días de la fecha del accidente, o de la fecha en que el empleador se haya dado cuenta del accidente, cuando el trabajador está completa o parciamente incapacitado por lo que resta del día o del turno.

2. El empleador debe suministrar el pago de los reclamos sin cobrarles a los trabajadores.

3. El empleador debe exhibir **AVISO** de Compensación al trabajador, preparado por el director.

4. El empleador debe pagar los beneficios de compensación aunque no tenga seguro.

5. En cuanto reciba aviso de un accidente, el empleador debe proporcionar al trabajador información por escrito para ayudarle a entender cuales son sus derechos y responsabilidades al obtener compensación.

EL EMPLEADOR DEBE COMPLETAR LA SIGUIENTE INFORMACIÓN PARA CADA TRABAJADOR LASTIMADO

SU RECLAMO SERA DIRIGIDO POR:

Compañia: CHUBB INDEMNITY INSURANCE COMPANY

Dirección: 2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Contacto: _____

Teléfono: _____

NOTICE OF ELECTION TO BE EXEMPT

Please thoroughly read the instructions before completing this application. Print legibly in each data entry field. If this application contains incomplete or inaccurate information or if the handwriting is not legible, it may cause a delay in the issuance of your exemption.

SECTION 1.

Applicant Name (please print): _____

Applicant's social security number: ____ / ____ / ____

Applicant's E-mail address (optional): _____

SECTION 2. I am applying for exemption as a (You must check only one box in this section):

CONSTRUCTION INDUSTRY ($50 FEE REQUIRED)

☐ Officer of a Corporation (Title): _____ **- OR -** ☐ Member of a Limited Liability Company (LLC)

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Officer of a Corporation (Title): _____)

The Division will accept a money order, a cashier's check, or an electronic payment made payable to the DFS WC Administration Trust Fund.

An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.

SECTION 3. The corporation of which you are an officer or the limited liability company of which you are a member must be registered and inanactive status with the Florida Division of Corporations. Applicants applying as an officer of a corporation must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number (document number shown on your Annual Report) on file with the Florida Division of Corporations.

SECTION 4. This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:

Name of Corporation or LLC: _____ FEIN : _____
AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

Business Name: _____ Phone : (___) _____
IF APPLICABLE – LIST FICTITIOUS NAME; DOING BUSINESS AS (DBA); ALSO KNOWN AS NAME (AKA)

Applicant's Address of Record: _____
INCLUDE APARTMENT OR SUITE NUMBER

City: _____ State: _____ Zip: _____ County: _____

Scope of Business or Trade: 1. _____ 2. _____ 3. _____ 4. _____

SECTION 5. List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer: _____

SECTION 6. If you have submitted an electronic payment for this application, write the transaction confirmation number in the following space: _____

SECTION 7. Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies? ☐ Yes ☐ No

IF YES, PLEASE LIST THE NAME(s) AND FEIN(s) OF THE AFFILIATED CORPORATION(s) OR LLC(s):

NAME: _____ **FEIN:** _____

SECTION 8. If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.

A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. **A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.**

B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. **THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.**

THIS APPLICATION IS CONTINUED ON PAGE 2

SECTION 9. **FRAUD NOTICE**

A. Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company or any other person, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree.

B. Attestation of applicant - By signing below, I attest that I have read, understand and acknowledge the foregoing notice.

_____

SIGNATURE OF APPLICANT

SECTION 10. You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business. **Carrier Name:** CHUBB INDEMNITY INSURANCE COMPANY

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers, including any affiliated corporations as provided in §440.02 Florida Statutes.

_____ _____

APPLICANT'S SIGNATURE DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this _____ day of _____, _____, by _____

Personally Known _____ OR Produced Identification _____ Type of Identification Produced _____

NOTARY SIGNATURE _____ My Commission Expires _____

Please mail or submit your completed application, application fee, and any required attachments to the district office nearest your place of business.

4415 Met ro Parkway, Suite 300
Ft. Myers, FL 33916
Telephone (239) 938-1840

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

3111 S. Dixie Highway, Suite # 123
West Palm Beach, FL 33405
Telephone (561) 837-5716

Live Oak Business Center
5969 Cattlemen Lane
Sarasota, FL 34232
Telephone (941) 329-1120

1313 N. Tampa Street, Suite # 503
Tampa, FL 33602
Telephone (813) 221-6506

921North Davis Street
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400West Robinson Street
Room #512, North Tower
Orlando, FL 32801
Telephone (407) 835-4406 or (407) 245-0896

499 Northwest 70th Ave., Suite # 116
Plantation, FL 33317
Telephone (954) 321-2906

1111 NE 25th Ave., Suite # 403
Ocala, FL 34470
Telephone (352) 401-5350

401 NW 2nd Avenue
Suite #321, South Tower
Miami, FL 33128
Telephone (305) 536-0306

TALLAHASSEE SUBMITTERS

Walk-in submissions:
2012 Capital Circle SE
Suite #102, Hartman Bldg.
Tallahassee, FL32399-2161
Telephone (850) 413-1609

Mail in submissions:
200 East Gaines Street
Tallahassee, FL 32399-4228
Telephone (850) 413-1609

STATE USE ONLY

Effective/Issue Date: _____

Expiration Date: _____

Control Number: _____

Postmark Date: _____

Payment Number: _____

Received Date:

"The collection of the social security number on this form is specifically authorized by Section 440.05(3), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have applied for and/or been issued a Certificate of Election To Be Exempt. It will also be used to identify information and documents in those database systems regarding individuals who have applied for and/or been issued a Certificate of Election To Be Exempt for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law."

STATE USE ONLY
Effective/Issue Date:
Control Number:
Postmark Date:
Received Date:

NOTICE OF REVOCATION OF ELECTION TO BE EXEMPT

PLEASE TYPE OR PRINT

I hereby revoke the exemption I currently have as a (check only one box in this section):

CONSTRUCTION INDUSTRY

☐ Corporate Officer (your corporate title: _____) ☐ Member of Limited Liability Company **-OR-**

NON-CONSTRUCTION INDUSTRY

☐ Corporate Officer (your corporate title: _____)

THIS REVOCATION OF ELECTION TO BE EXEMPT APPLIES ONLY TO THE PERSON SIGNING THE REVOCATION AND ONLY TO THE CORPORATION/LLC THAT IS LISTED IN THE FOLLOWING SECTION:

Corporation or LLC Name:			
Business Mailing Address:	City:	State:	Zip:
County:	Phone No.: ( )	FEIN:	Corporate registration number:

Scope of Business or Trade of Applicant Listed on Notice of Election to be Exempt:

1. _____ 2. _____ 3. _____ 4. _____

You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business.

Carrier Name: CHUBB INDEMNITY INSURANCE COMPANY

PURSUANT TO SECTION 440.05 (3) FLORIDA STATUTES, UPON FILING A NOTICE OF REVOCATION, IF YOU ARE AN OFFICER WHO IS A SUBCONTRACTOR OR AN OFFICER OF A CORPORATE SUBCONTRACTOR, YOU MUST NOTIFY YOUR CONTRACTOR THAT YOU HAVE REVOKED YOUR EXEMPTION.

PURSUANT TO SECTION 440.05 (3) FLORIDA STATUTES, UPON REVOCATION OF A CERTIFICATE OF ELECTION OF EXEMPTION BY THE DEPARTMENT, THE DEPARTMENT SHALL NOTIFY THE WORKERS' COMPENSATION CARRIER(S) IDENTIFIED IN THE REQUEST FOR EXEMPTION.

_____

TYPE/PRINT NAME OF EXEMPTION HOLDER

_____ _____

SIGNATURE OF EXEMPTION HOLDER DATE SIGNED

Workers' Compensation Information Online - http://www.myfloridacfo.com

SUBMIT THIS FORM TO THE DISTRICT OFFICE LISTED BELOW THAT IS CLOSEST TO YOUR PLACE OF BUSINESS:

WORKERS' COMPENSATION COMPLIANCE FIELD OFFICES

4415 Metro Parkway
Suite #300
Ft. Myers, FL 33916
Telephone (239) 938-1840

2686 Chapman Dr.
Panama City, FL 32405
Telephone (850) 747-5425

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

3111 South Dixie Hwy.
Suite #123
West Palm Beach, FL 33405
Telephone (561) 837-5716

Live Oak Business Center
5969 Cattlemen Lane
Sarasota, FL 34232
Telephone (941) 329-1120

921 N. Davis St.
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400 West Robinson St.
Room #211 North Tower
Orlando, FL 32801
Telephone (407) 245-0896

499 Northwest 70th Avenue
Suite #116
Plantation, FL 33317
Telephone (954) 321-2906

1313 N. Tampa St.
Suite #503
Tampa, FL 33602
Telephone (813) 221-6506

401 NW 2nd Ave.
Suite #321 South Tower
Miami, FL 33128
Telephone (305) 536-0306

1111 NE 25th Ave.
Suite #403
Ocala, FL 34470
Telephone (352) 401-5350

TALLAHASSEE SUBMITTERS

Walk-in submissions:
2012 Capital Circle SE
Suite #102 Hartman Bldg.
Tallahassee, FL 32399-2161
Telephone (850) 413-1609

Mail in submissions:
200 East Gaines Street
Tallahassee, FL 32399-4228
Telephone (850) 413-1609

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Instructions

Purpose of Form

This form is intended to convey ownership information to the WCIRB in the following cases:

1. **Change in Ownership**
   There has been a change in ownership.
2. **Combinability of Entities**
   Entities should be combined or separated for experience rating purposes.

Completed Form Examples

The regulations regarding Changes in Ownership and the Combinability of Entities are found in the *California Workers' Compensation Experience Rating Plan — 1995* (ERP).

The ERP is available on the WCIRB's website. The website also contains examples to assist you in completing this form. To view the ERP and completed examples, go to www.wcirbonline.org/.

Use of Form

This form is intended for use by:

- Insurers
- Agents or brokers
- Policyholders
- Third Party Entities (TPEs) authorized by member insurer

Insurer Review Required

If you (submitting party) are not the insurer, send the completed form to the insurer. The insurer must review the form to verify the information for consistency and to address any underwriting issues.

Form Completion

- This form can be completed electronically
- If not completed electronically, print or type all information
- This form requires a signature. It must be printed and signed by the party submitting the information
- Complete all required sections
- It is recommended that the insurer submit the completed form
- Incomplete information may result in a delay or an inability to process your request
- After reviewing the information submitted, the WCIRB may require additional information and/or corroborating documentation in order to resolve this matter

Sending the Form

- You may mail, fax or email this form (see information below)
- To email, print the form, sign, scan as a pdf and email to customerservice@wcirbonline.org

Questions

Call WCIRB Customer Service toll free
888.CA WCIRB (229.2472) 7:30 a.m. - 5:00 p.m. PST.

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Incomplete information may result in a delay or an inability to process your request.

Part I — Contact Information of Party Submitting This Form (Required Information)

Submitted By (Print Name) | Title

Signature | Date

Company | Indicate Relationship to Policyholder

Mailing Address

City | State | Zip

Telephone | Fax | Email

Part II — Employer/Policyholder Contact Information (Optional Information)

Submitted By (Print Name) | Title

Signature | Date

Company

Mailing Address

City | State | Zip

Telephone | Fax | Email

Part III — Reason for Submitting Form 601 (Check One Box)

☐ **Entity changed ownership.**
If this box is selected, complete Part IV, pages 2-5.

☐ **Entities should be combined or separated. (Do not check if the box for "Entity changed ownership" is checked.)**
Check this box if two or more entities should be combined or separated for experience rating purposes — neither entity has changed ownership. Answer the question below and complete Part V, page 6.

Specify below whether the entities should be combined or separated.

☐ Combine

☐ Separate

Note: You may be required to submit corroborating documentation to support your answers.

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472, Fax 415.778.7272 | customerservice@wcirbonline.org, www.wcirbonline.org

Form PE601.09-0407
08 10 0668 (Ed. 4-09)

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Part IV — Change in Ownership

1. **Provide a brief narrative (Required Information).**
Briefly explain the change in ownership. Please describe the nature of change in ownership, e.g., all or a portion of the ownership in [entity] was sold, transferred or conveyed from one person to another; [Entity] was dissolved or non-operative and [new entity] was formed; two or more corporations [name the corporations] underwent a statutory merger or consolidation; all or most of the tangible or intangible assets of [entity] were sold, transferred or conveyed to [entity]; or a trusteeship or receivership was set up, either voluntarily or at the direction of the courts, to operate [entity]. (Attach additional page(s) if necessary.)

2. **Date of ownership change.**

(MM/DD/YY)

3. **Do the buyer and the seller have a family relationship?**
For this purpose, family members include father, mother, husband, wife, son, daughter, stepson, stepdaughter, grandson and granddaughter only.

☐ **No** – There is no family relationship, as defined above, between the buyer and the seller.

☐ **Yes** – There is a family relationship between the buyer and the seller.
Describe below the family relationship, e.g., the seller is the father of the buyer.

4. **Did the buyer acquire all (100%) of the seller's California operations?**

☐ **Yes – The buyer acquired all (100%) of the seller's California operations.**
If yes, answer question A. directly below.

A. Did 50% or more of the employees who conducted the acquired operations for any period of time within the first 90 days after the sale also work for the seller to conduct such operations for any period of time within the 90 days immediately preceding the sale?

☐ Yes

☐ No

☐ **No – The buyer did not acquired all (acquired less than100%) of the seller's California operations.**
If no, answer question B. directly below.

B. Did 50% or more of the employees employed in all of the sellers' operations for any period of time within the 90 days immediately preceding the sale also work for the new owner for any period of time within the first 90 days after the sale to conduct the acquired operations?

☐ Yes

☐ No

Note: You may be required to submit corroborating documentation to support your answers.

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472, Fax 415.778.7272 | customerservice@wcirbonline.org, www.wcirbonline.org

Form PE601.09-0407
08 10 0668 (Ed. 4-09)

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Part IV — Change in Ownership

5. **Required details for each entity that underwent a Change in Ownership.**
(Attach additional page(s) if necessary.)

Before Change		After Change	
Legal Name of Entity That Underwent Ownership Change Include dba. If more than a single entity underwent an ownership change, provide information for each entity.		**Legal Name of Entity That Underwent Ownership Change** Include dba. If more than a single entity underwent an ownership change, provide information for each entity.	
Address(es) Indicate the physical address for each California location owned by the entity.		**Address(es)** Indicate the physical address for each California location owned by the entity.	
Ownership of Entity. Check box. ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state		**Ownership of Entity. Check box.** ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state	
Insurer and Policy Number		**Insurer and Policy Number**	
Bureau File Number (If available)		**Bureau File Number (If available)**	
Federal Employee Identification Number (FEIN)		**Federal Employee Identification Number (FEIN)**	

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472, Fax 415.778.7272 | customerservice@wcirbonline.org, www.wcirbonline.org

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08 10 0668 (Ed. 4-09)

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Part IV — Change in Ownership

6. **Does the buyer or the seller have a greater than 50% ownership interest in any other legal entities operating and insured in California?**

☐ Yes – Complete Items 7 and/or 8, below.

☐ No – No further information is necessary.

7. **BUYER'S other operations (entities).**
List below all other California operations, if any, in which the buyer(s) has a greater than 50% ownership interest. (Attach additional pages if necessary.)

Entity 1		Entity 2	
Legal Name of Entity Include dba.		**Legal Name of Entity** Include dba.	
Address(es) Indicate the physical address for each California location owned by the entity.		**Address(es)** Indicate the physical address for each California location owned by the entity.	
Ownership of Entity. Check box. ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state		**Ownership of Entity. Check box.** ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state	
Insurer and Policy Number		**Insurer and Policy Number**	
Bureau File Number (If available)		**Bureau File Number (If available)**	
Federal Employee Identification Number (FEIN)		**Federal Employee Identification Number (FEIN)**	

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Form PE601.09-0407
08 10 0668 (Ed. 4-09)

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Part IV — Change in Ownership

8. **SELLER'S other operations (entities).**
List below all other California insured operations, if any, in which the seller(s) has a greater than 50% ownership interest. (Attach additional page(s) if necessary.)

Entity 1		Entity 2	
Legal Name of Entity Include dba.		**Legal Name of Entity** Include dba.	
Address(es) Indicate the physical address for each California location owned by the entity.		**Address(es)** Indicate the physical address for each California location owned by the entity.	
Ownership of Entity. Check box. ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state		**Ownership of Entity. Check box.** ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state	
Insurer and Policy Number		**Insurer and Policy Number**	
Bureau File Number (If available)		**Bureau File Number (If available)**	
Federal Employee Identification Number (FEIN)		**Federal Employee Identification Number (FEIN)**	

WCIRB Customer Service | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472, Fax 415.778.7272 | customerservice@wcirbonline.org, www.wcirbonline.org

Form PE601.09-0407
08 10 0668 (Ed. 4-09)

Notification of Change in Ownership and/or Combinability of Entities
Form 601 (Rev. 04/2009)

Part V — Combinability of Entities (Entities Should Be Combined or Separated)

If an entity changed ownership in the past five years, do not complete this Part; complete Part IV, page 2.

1. **Provide a brief narrative (Required Information).**
   Briefly explain why the entities should be combined or separated. (Attach additional page(s) if necessary.)

2. **Required details for each entity that underwent a Change in Ownership.**
   (Attach additional pages if necessary.)

Entity A		Entity B	
Legal Name of Entity Include dba. If more than two entities should be combined or separated, attach additional page(s).		**Legal Name of Entity** Include dba. If more than two entities should be combined or separated, attach additional page(s).	
Address(es) Indicate the physical address for each California location owned by the entity.		**Address(es)** Indicate the physical address for each California location owned by the entity.	
Ownership of Entity. Check box. ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state		**Ownership of Entity. Check box.** ☐ **Sole Proprietor** – Provide name ☐ **Partnership** – List all general partners ☐ **Corporation** – List voting stockholders, include % held ☐ **LLC** – List all members ☐ **Joint Venture** – List each joint venturer ☐ **Trust** – List all trustees ☐ **Non-Profit** – If no voting stock or members, list each member of the board ☐ **Other** Please state	
Insurer and Policy Number		**Insurer and Policy Number**	
Bureau File Number (If available)		**Bureau File Number (If available)**	
Federal Employee Identification Number (FEIN)		**Federal Employee Identification Number (FEIN)**	

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Form PE601.09-0407
08 10 0668 (Ed. 4-09)

NOTICE OF ELECTION TO ACCEPT OR REJECT AN INSURANCE DEDUCTIBLE FOR ILLINOIS WORKERS' COMPENSATION MEDICAL BENEFITS

Illinois Law permits an employer to buy workers' compensation insurance with a deductible. The deductible is for medical benefits only and applies to each accident. A full description of how the deductible works is printed as a sample Endorsement on the other side of this Notice.

Please show whether or not you want the deductible by initialing the appropriate choice below.

[ ] Yes, I want a deductible of $1,000 applied to medical benefits under the Illinois Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

[ ] No, I do not want the deductible described in this Notice.

DATE

EMPLOYER

NAME

TITLE

(13)7575-25-17

POLICY NUMBER

ILLINOIS MEDICAL BENEFITS DEDUCTIBLE ENDORSEMENT

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

1. Part One (Workers' Compensation Insurance) applies to medical benefits only in excess of a deductible amount of $1000. This deductible applies separately to each accident, regardless of the number of persons injured in the accident.

2. We will pay the deductible amount for you, but you must reimburse us within 30 days after we send you notice that payment is due. If you fail to reimburse us, we may cancel the policy in accordance with Illinois cancelation law. We may keep the amount of unearned premium that will reimburse us for the payments we made. These rights are in addition to other rights we have to be reimbursed.

Chubb Group of Insurance Companies
15 Mountain View Road, Warren, NJ 07060

INFORMATION PAGE
WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

Item 1. Name & Mailing Address of the Insured

PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

SEE EXTENSION OF INFO PG-NAMED INSURED
FEIN 720509664 NJTIN: 720509664000
TEL#: (985)893-4097 # of EMP:
UI#:
Insured is: CORPORATION

Name & Address of the Producer

STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Issued by CHUBB INDEMNITY INSURANCE COMPANY
a stock insurance company
incorporated in NEW YORK

N.C.C.I. Carrier Code 31720

Policy Number (13)7575-25-17

Previous Policy Number (12)7575-25-17

OTHER WORK PLACES NOT SHOWN ABOVE - SEE ATTACHED EXTENSION OF INFORMATION PAGE

Item 2. POLICY PERIOD

12:01 A.M. standard time at the insured's mailing address FROM 08/19/12 TO 08/19/13

Item 3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the states listed here: Refer To Extension of Information Page "Covered States"

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each state listed in Item 3A. 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 states designated in Item 3.A and ND, OH, WA, WY,

D. Endorsements (Form No.) Refer To Extension of Information Page "List of Endorsements & Schedules"

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

Refer to Extension of Information Page

Minimum Premium: 698		Total Estimated Premium	$ 99,301
Minimum Premium State: CALIFORNIA		Total State Surcharges	$ 1,270
Expense Constant: NEW YORK	($450 INCL)	Total Estimated Charge	$ 100,571
Premium Adjustment Period: AT EXPIRATION		Deposit Amount	$ 26,095

CHUBB GROUP OF INSURANCE COMPANIES:
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

Authorized Representative and Date Signed

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.
NAMED INSURED

It is agreed that Item 1 of the Workers Compensation and Employers Liability Policy Information Page includes the following Named Insureds:

	NAME OF INSURED	F.E.I.N.
0001	PAMLAB INC.	720509664 NJTIN: 720509664000
0002	PAN AMERICAN LABORATORIES INC	720509664
0003	RED RIVER PHARMA, LLC	731645664
0004	RED RIVER DEVELOPMENT, LLC	731645664
0005	PAMLAB INC.	274128130
0006	ZERXIS PHARMA, L.L.C.	720509664
0007	PAN AMERICAN LABORATORIES, LLC	721517014
0008	RED RIVER PHARMA MANUFACTURING, L.L.C.	731645664
0009	BRAND DIRECT HEALTH, LLC	271236937

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

WC 00 00 01A (Rev. 5-88)

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.A.
COVERED STATES

It is agreed that Item 3.A of the Workers Compensation and Employers Liability Policy Information Page includes the following states:

State	Risk I.D.	State I.D. No.
ALABAMA	917801010	
ARIZONA	917801010	
ARKANSAS	917801010	
CALIFORNIA		
COLORADO	917801010	
CONNECTICUT	917801010	
DELAWARE		
DISTRICT OF COLUMBIA	917801010	
FLORIDA	917801010	
GEORGIA	917801010	
ILLINOIS	917801010	
INDIANA	917801010	
IOWA	917801010	
KANSAS	917801010	
KENTUCKY	917801010	
LOUISIANA	917801010	
MARYLAND	917801010	
MASSACHUSETTS	917801010	
MICHIGAN		
MINNESOTA	917801010	
MISSISSIPPI	917801010	
MISSOURI	917801010	
NEBRASKA	917801010	
NEVADA	917801010	

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Authorized Representative

Issue Date 09/12/12 HOU CLD 028

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Producer Number 2-24843 000

Name of Company
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Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.A.
COVERED STATES (Continued)

State	Risk I.D.	State I.D. No.
NEW HAMPSHIRE	917801010	
NEW JERSEY		
NEW MEXICO	917801010	
NEW YORK	917801010	
NORTH CAROLINA	917801010	
NORTH DAKOTA		
OHIO		
OKLAHOMA	917801010	
OREGON	917801010	
PENNSYLVANIA	3025712	
SOUTH CAROLINA	917801010	
TENNESSEE	917801010	
TEXAS	917801010	
UTAH	917801010	
VIRGINIA	917801010	
WASHINGTON		
WEST VIRGINIA	917801010	

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Issue Date 09/12/12 HOU CLD

028

WC 00 00 01A (Rev. 5-88)

CHUBB

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PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES

It is agreed that Item 3.D. of the Workers Compensation and Employers Liability Policy Information Page includes the following endorsements and schedules:

IT IS AGREED THAT THE FOLLOWING ENDORSEMENT(S) ARE PART OF THIS POLICY

FORM NUMBER	ED/REV DATE	FORM TITLE
WC 00 00 00B	07 2011	WORK COMP & EMPLOYERS' LIABILITY POLICY
WC 00 00 01A	05 1988	INFORMATION PAGE/DEC PAGE
WC 00 03 03C	10 2004	EMPLOYERS LIABILITY COV. ENDT. SIMPLIFIED
WC 00 03 13	04 1984	WAIVER OF RIGHT TO RECOVER FROM OTHERS
WC 00 04 06	03 1985	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 06A	08 1995	PREMIUM DISCOUNT ENDORSEMENT
WC 00 04 14	07 1990	NOTIFICATION OF CHANGE IN OWNERSHIP
WC 00 04 19	01 2001	PREMIUM DUE DATE ENDORSEMENT
WC 00 04 21C	09 2008	CATASTROPHE(OTHER THAN TERRORISM)ENDORSEMENT
WC 00 04 22A	09 2008	TERRORISM RISK PGM REAUTH ACT DISCLOSURE END
WC 02 06 01	05 1986	ARIZONA CANCELLATION ENDORSEMENT
WC 03 06 01A	04 1992	ARKANSAS AMENDATORY ENDORSEMENT
WC 04 03 01B	01 2012	POLICY AMENDATORY ENDORSEMENT-CALIFORNIA
WC 04 03 60A	11 1999	EMPLOYERS LIABILITY COV ENDT,
WC 04 06 01A	12 1993	CALIFORNIA CANCELLATION ENDORSEMENT
WC 05 04 02	11 1990	COLORADO CLASSIFICATION ENDORSEMENT
WC 06 03 01	04 1984	CONNECTICUT APPLICATION OF WORKERS COMP
WC 06 03 03C	07 2011	CONNECTICUT WORK COMP FUNDS ENDORSEMENT
WC 06 06 01	01 2003	CONNECTICUT NONRENEWAL ENDORSEMENT
WC 07 06 01	07 1988	DELAWARE NONRENEWAL ENDORSEMENT
WC 08 06 01	04 1984	DISTRICT OF COLUMBIA CANCELLATION
WC 09 03 03	08 2005	FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSE

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FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	ED/REV DATE	FORM TITLE
WC 09 04 03A	01 2008	FLORIDA TERRORISM RISK INS. REAUTHORIZATION
WC 09 06 06	10 1998	FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEA
WC 10 06 01A	04 1993	GEORGIA CANCELLATION, NONRENEWAL & CHANGE
WC 12 06 01D	07 2011	ILLINOIS AMENDATORY ENDORSEMENT
WC 15 04 01A	01 2010	KANSAS FINAL PREMIUM ENDORSEMENT
WC 15 06 01A	01 1987	KANSAS CANCELLATION AND NONRENEWAL
WC 16 03 05	06 2007	KENTUCKY PART ONE WC INSURANCE ENDORSEMENT
WC 16 06 01	12 1997	KENTUCKY CANCELATION & NONRENEWAL ENDT
WC 16 06 02	10 1999	KENTUCKY NOTICE OF APPEAL RIGHT ENDORSEMENT
WC 17 03 03	12 2000	LOUISIANA DUTY TO DEFEND ENDORSEMENT
WC 17 06 01E	11 2011	LOUISIANA AMENDATORY ENDORSEMENT
WC 17 06 02A	02 1996	LOUISIANA COST CONTAINMENT ACT
WC 19 06 01E	01 2009	MD CANCELLATION AND NONRENEWAL ENDORSEMENT
WC 20 03 01	04 1984	MASSACHUSETTS LIMITS OF LIABILITY
WC 20 03 02A	09 2008	MASSACHUSETTS - ASSESSMENT CHARGE
WC 20 03 03D	08 2010	MASSACHUSETTS NOTICE TO POLICYHOLDER
WC 20 04 05	06 2001	MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT
WC 20 06 01A	07 2008	MASSACHUSETTS CANCELLATION
WC 21 03 03A	06 1997	MICHIGAN NOTICE TO POLICYHOLDER ENDORSEMENT
WC 21 03 04	04 1984	MICHIGAN LAW ENDORSEMENT
WC 21 06 01	04 1984	MICHIGAN DUAL OR JOINT EMPLOYMENT ENDT
WC 22 00 00A	11 2003	MINNESOTA AMENDATORY ENDORSEMENT
WC 22 03 01	01 2005	MN COMPLIANCE APPLICABLE TRADE SANCTIONS LAWS
WC 22 06 01D	08 2006	MN CANCELLATION & NONRENEWAL ENDT.
WC 24 06 01B	01 1996	MISSOURI CANCELLATION AND NONRENEWAL

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

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MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
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1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	ED/REV DATE	FORM TITLE
WC 24 06 04	07 1999	MISSOURI AMENDATORY ENDORSEMENT
WC 26 06 01C	07 1996	NEBRASKA CANCELLATION AND NONRENEWAL
WC 27 06 01C	10 2008	NEVADA CANCELATION AND NONRENEWAL ENDORSEMENT
WC 28 06 04	04 1992	NEW HAMPSHIRE AMENDATORY ENDORSEMENT
WC 29 03 06B	07 2007	NJ PART TWO EMPLOYERS LIABILITY ENDT
WC 30 03 02	04 1984	NEW MEXICO SAFETY DEVICE EXCLUSION
WC 30 03 03	04 1984	NEW MEXICO VOLUNTEER WORKER
WC 30 06 01	01 1990	NEW MEXICO CANCELLATION AND NONRENEWAL
WC 31 03 08	04 1984	NEW YORK LIMIT OF LIABILITY
WC 31 03 19F	02 2011	NY CONSTRUCTION CLASSIFICATION PREMIUM ADJUST
WC 32 03 01B	10 2001	NORTH CAROLINA AMENDED COVERAGE
WC 34 03 01B	04 1992	OHIO EMPLOYERS LIABILITY COVERAGE
WC 35 03 03	12 2010	OKLAHOMA EMPL. LIABILITY INTENTIONAL TORT END
WC 35 06 01E	07 2006	OK CANCELLATION, NONRENEWAL & CHANGE
WC 35 06 04	08 1999	OKLAHOMA ELECTION OF COVERAGE NOTIFICATION EN
WC 36 03 06	01 2002	OREGON LIMITS OF LIABILITY ENDORSEMENT
WC 36 04 06	10 2001	OREGON PREMIUM DUE DATE ENDORSEMENT
WC 36 06 01E	01 2008	OREGON CANCELLATION ENDT.
WC 37 06 01	04 1984	PENNSYLVANIA INSPECTION OF MANUALS
WC 37 06 02	04 1984	PENNSYLVANIA NOTICE
WC 37 06 03A	08 1995	PA ACT 86 - 1986 NONRENEWAL, NOT OF INCREASE
WC 37 06 04	10 1999	PENNSYLVANIA EMPLOYER ASSESSMENT ENDORSEMENT
WC 42 03 01F	01 2000	TEXAS AMENDATORY ENDORSEMENT
WC 42 03 04A	01 2000	TEXAS WAIVER OF OUR RIGHT TO RECOVER FRM OTHR
WC 42 04 07	03 2002	TEXAS AUDIT PREMIUM AND RETROSPECTIVE PREMIUM

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Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

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Attached to and Forming Part of
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Policy Period 08/19/12 **to** 08/19/13

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Name of Company
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EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	ED/REV DATE	FORM TITLE
WC 43 06 02	07 2002	UTAH CANCELLATION ENDORSEMENT
WC 45 06 02	07 1993	VIRGINIA AMENDATORY ENDORSEMENT
WC 47 03 01A	07 2008	WV EMPLOYERS LIABILITY INS INT ACT EXC ENDT
WC 47 03 02	07 2008	WV WC INS RECOVERY FROM OTHERS ENDORSEMENT
WC 47 06 01	07 2008	WEST VIRGINIA CANCELLATION ENDORSEMENT
WC 642C	11 2002	WORKERS COMPENSATION DISCLOSURE FORM IMPORTAN
WC 7894	02 1993	ILLINOIS NOTICE TO ACCEPT/REJ MED BENEFITS
WC 8093A	07 2004	FLORIDA APPLICATION FOR DRUG FREE WKPLC
WC 99 01 01	01 2008	TX TERRORISM RISK INSURANCE PROGRAM REAUTH.
WC 99 03 04	07 2008	CA WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS
WC 99 04 01	01 2008	TEXAS TERRORISM PREMIUM ENDORSEMENT
WC 99 06 05	05 1988	INSTALLMENTS
08 02 0223	01 2007	NJ NOTICE OF ELECTION - PROPRIETORS & PARTN
08 02 0251	01 1997	TEXAS DEDUCTIBLE NOTICE OF ELECTION
08 02 0259	01 2004	COMPL. W/APPLIC TRADE SANCTIONS (WC 99 03 03)
08 10 0239	10 2003	CONFIDENTIAL REQUEST FOR INFORMATION
08 10 0250	01 2009	TEXAS COMPLAINT NOTICE
08 10 0279	04 2008	GEORGIA DEDUCTIBLE DISCLOSURE NOTICE
08 10 0312	08 2005	IMPORTANT NOTICE TO POLICYHOLDER -TEXAS
08 10 0319	03 1991	CONNECTICUT NOTICE TO PRODUCERS-SURCHARG
08 10 0350	07 1993	MISSOURI POLICYHOLDER INFORMATION NOTICE
08 10 0352	01 1993	COLORADO DEDUCTIBLE DISCLOSURE NOTICE
08 10 0353	02 2004	MINNESOTA NOTICE OF SERVICES
08 10 0355	03 2009	ARKANSAS ACCIDENT PREVENTION SERVICES
08 10 0359	06 1997	OKLAHOMA SMALL DEDUCTIBLE ACCEPT/REJECT

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

CHUBB

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P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.

LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	ED/REV DATE	FORM TITLE
08 10 0361	09 1993	OKLAHOMA FRAUD NOTICE - WARNING
08 10 0368	03 2006	KANSAS OMBUDSMAN NOTICE - ENGLISH
08 10 0369	03 2005	KANSAS OMBUDSMAN NOTICE - SPANISH
08 10 0371	01 2008	NEW YORK DEDUCTIBLE DISCLOSURE NOTICE
08 10 0391	03 2004	CALIFORNIA LOSS CONTROL SERVICES NOTICE
08 10 0395	03 2004	MISSOURI LOSS CONTROL SERVICES NOTICE
08 10 0396B	05 2002	POLICYHOLDER NOTICE: CALIFORNIA WORKERS COMP
08 10 0397	01 2009	COLORADO NOTICE TO POLICYHOLDERS
08 10 0398	01 2011	CALIFORNIA RIGHT TO RATING & DIV INFO
08 10 0405	03 2004	KANSAS IMPORTANT NOTICE
08 10 0406	03 2004	OKLAHOMA LOSS CONTROL NOTICE
08 10 0422	10 1997	SC APP FOR DRUG & ALCHL FREE WKPLC PREM CR PG
08 10 0426	07 1997	VA APP FOR DRUG FREE WORKPLACE PREMIUM CR PG
08 10 0448	01 1994	FLORIDA WORKERS' COMPENSATION DISCLOSURE NOT
08 10 0457	02 2000	NOTICE OF ELECTION TO BE EXEMPT
08 10 0458	02 2000	REVOCATION OF ELECTION TO BE EXEMPT
08 10 0465	05 1998	NEW YORK APPLICATION FOR DRUG FREE WORK PLACE
08 10 0466A	06 2001	PRIVACY POLICY AND PRACTICES NOTICE
08 10 0468	12 2001	CA INSURANCE GUARANTEE ASSOCIATION (CIGA)
08 10 0470	03 2004	IMPORTANT NOTICE PENNSYLVANIA WORKERS' COMPEN
08 10 0476	10 2010	NY LOSS COST REVISION EXPLANATORY MEMO 2010
08 10 0512	03 2004	OREGON WORK COMP LOSS CONTROL NOTICE
08 10 0543	04 2005	NOTICE TO POLICYHOLDER
08 10 0544	04 2005	NOTICE TO PRODUCER
08 10 0551	10 2010	CALIFORNIA EMPLOYEE MPN INFORMATION

All Other Terms and Conditions Remain Unchanged

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Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

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1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	ED/REV DATE	FORM TITLE
08 10 0563	07 2005	GEORGIA CORPORATE OFFICER ELECTION/REJECTION
08 10 0578	10 1991	ARIZONA EMPLOYEE NOTICE TO REJECT WKC
08 10 0579	10 1991	ARIZONA EMPLOYEES NOTICE REVOKE REJECT
08 10 0634	07 2007	TX HEALTH CARE NETWORK NOTICE TO POLICYHOLER
08 10 0635	07 2007	TEXAS HEALTH CARE NETWORK NOTICE TO PRODUCER
08 10 0639	08 2007	PA WORKERS COMPENSATION EMPLOYEE NOTIFICATION
08 10 0647	01 2009	DELAWARE NOTICE TO ACCEPT/REJECT DEDUCTIBLE
08 10 0648	01 2008	FLORIDA NOTICE OF ELECTION TO BE EXEMPT
08 10 0649	01 2008	FLORIDA REVOCATION OF ELECTION TO BE EXEMPT
08 10 0650	01 2008	FLORIDA NOTICE OF ELECTION OF COVERAGE
08 10 0651	01 2008	FLORIDA REVOCATION OF ELECTION OF COVERAGE
08 10 0668	04 2009	NOTIFICATION OF CHANGE OF OWNERSHIP
99 10 0242	01 2003	ARKANSAS POLICY INFORMATION NOTICE
99 10 0256	07 1988	ILLINOIS POLICY INFORMATION NOTICE
99 10 0289	06 1990	INDIANA NOTICE TO FILE COMPLAINTS
99 10 0299	07 2007	TEXAS IMPORTANT NOTICE/ COMPLAINT-INFO NUMBER
99 10 0353	01 2006	POLICYHOLDER INFORMATION NOTICE FLORIDA
99 10 0371	06 1995	INDIANA NOTICE TO POLICYHOLDER
99 10 0732	12 2007	NOTICE TO POLICYHOLDERS - TERRORISM RISK ACT
99 10 0786	01 2004	VIRGINIA IMPORTANT INFORMATION
99 10 0792	09 2004	IMPORTANT NOTICE - OFAC
99 10 0820	02 2005	FLORIDA NOTICE OF RISK MANAGEMENT
99 10 0872	06 2007	AOD POLICYHOLDER NOTICE
99 10 0930	01 2012	IMPORTANT NOTICE - DELAWARE CIVIL UNION

IT IS AGREED THAT THE FOLLOWING SCHEDULE(S) ARE PART OF THIS POLICY

All Other Terms and Conditions Remain Unchanged

Authorized Representative

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	FORM TITLE	SCHEDULE NUMBER
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-01-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-02-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-03-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-04-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-05-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-06-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-07-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-08-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-09-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-10-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-12-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-13-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-14-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-15-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-16-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-17-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-19-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-20-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-21-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-22-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-23-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-24-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-26-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-27-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-28-0001

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 3.D.
LIST OF ENDORSEMENTS AND SCHEDULES (Continued)

FORM NUMBER	FORM TITLE	SCHEDULE NUMBER
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-29-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-30-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-31-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-32-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-33-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-34-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-35-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-36-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-37-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-39-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-41-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-42-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-43-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-45-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-46-0001
WC 00 00 01 A	EXTENSION OF INFORMATION PAGE	RENL-0001-47-0001

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

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Policy Number (13)7575-25-17

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Effective Date 08/19/12

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

OTHER WORKPLACES AND LOCATIONS OF THE INSURED

RATED NAME/LOCATION LINK	ADDRESS	#OF EMP.	SIC CODE	UI#
0001-03-0001	ARKANSAS		325412	
0001-04-0001	CALIFORNIA		2834	
0001-06-0001	CONNECTICUT		325412	
0001-10-0001	GEORGIA		325412	
0001-12-0001	ILLINOIS		325412	
0001-14-0001	IOWA		325412	
0001-20-0001	MASSACHUSETTS		2834	
0001-22-0001	MINNESOTA		2834	03273299
0001-28-0001	NEW HAMPSHIRE		325412	
0001-32-0001	NORTH CAROLINA		2834	
0001-33-0001	NORTH DAKOTA		2834	
0001-34-0001	OHIO		2834	
0001-37-0001	PENNSYLVANIA		2834	
0001-39-0001	SOUTH CAROLINA		325412	
0001-45-0001	VIRGINIA		325412	
0001-46-0001	WASHINGTON		2834	
0001-01-0001	NO SPECIFIC LOCATION AL		325412	
0001-02-0001	NO SPECIFIC LOCATION AZ		325412	
0001-05-0001	NO SPECIFIC LOCATION CO		325412	

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

WC 00 00 01A (Rev. 5-88)

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

OTHER WORKPLACES AND LOCATIONS OF THE INSURED (Continued)

0001-07-0001	NO SPECIFIC LOCATION DE		2834	
0001-08-0001	NO SPECIFIC LOCATION DC		325412	
0001-09-0001	NO SPECIFIC LOCATION FL	2	325412	
0001-13-0001	NO SPECIFIC LOCATION IN		325412	
0001-15-0001	NO SPECIFIC LOCATION KS		325412	
0001-16-0001	NO SPECIFIC LOCATION KY	2	325412	
0001-17-0001	NO SPECIFIC LOCATION LA		325412	
0001-19-0001	NO SPECIFIC LOCATION MD		325412	
0001-21-0001	NO SPECIFIC LOCATION MI		2834	
0001-23-0001	NO SPECIFIC LOCATION MS	2	325412	8413792000

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

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Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

OTHER WORKPLACES AND LOCATIONS OF THE INSURED (Continued)

0001-24-0001	NO SPECIFIC LOCATION MO		325412
0001-26-0001	NO SPECIFIC LOCATION NE		325412
0001-27-0001	NO SPECIFIC LOCATION NV	2	325412
0001-29-0001	NO SPECIFIC LOCATION NJ		2834
0001-30-0001	NO SPECIFIC LOCATION NM	2	325412
0001-31-0001	NO SPECIFIC LOCATION NY		2834
0001-35-0001	NO SPECIFIC LOCATION OK		325412
0001-36-0001	NO SPECIFIC LOCATION OR		325412
0001-41-0001	NO SPECIFIC LOCATION TN	2	325412
0001-42-0001	NO SPECIFIC LOCATION TX		325412

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

OTHER WORKPLACES AND LOCATIONS OF THE INSURED (Continued)

0001-43-0001	NO SPECIFIC LOCATION UT		325412	
0001-47-0001	NO SPECIFIC LOCATION WV		2834	
NON - RATED NAME/LOCATION LINK	ADDRESS	#OF EMP.	SIC CODE	UI#
0002-17-0100	NO SPECIFIC LOCATION LA		325412	
0003-17-0100	NO SPECIFIC LOCATION LA		325412	
0004-17-0100	NO SPECIFIC LOCATION LA		325412	
0005-27-0100	6100 NEIL ROAD, SUITE 500 RENO NV 89511	2	325412	
0006-17-0100	4099 HWY 190 COVINGTON LA 70433		325412	
0007-17-0100	NO SPECIFIC LOCATION LA		325412	
0008-17-0100	NO SPECIFIC LOCATION LA		325412	

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

WC 00 00 01A (Rev. 5-88)

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.
P.O. BOX 8950
MANDEVILLE LA 70470

FEIN 720509664 NJTIN: 720509664000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 1.

OTHER WORKPLACES AND LOCATIONS OF THE INSURED (Continued)

NON - RATED NAME/LOCATION LINK	ADDRESS	#OF EMP.	SIC CODE	UI#
0009-17-0100	NO SPECIFIC LOCATION LA		**325412**	

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

WC 00 00 01A (Rev. 5-88)

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION AL
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-01-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	848,286	.86	7,295
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.41	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				204
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				7,499

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION AZ
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-02-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	332,267	.46	1,528
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.21	0
INCREASED LIMITS PART TWO 2.0% CODE 9812				31
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				1,559

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
ARKANSAS

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-03-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	427,412	.28	1,197
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.15	0
INCREASED LIMITS PART TWO 3.3% CODE 9812				40
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				1,237

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
CALIFORNIA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-04-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS - OUTSIDE	8742	479,251	.84	4,026
CLERICAL OFFICE EMPLOYEES-N.O.C.	8810	IF ANY	.70	0
COMPANY SURCHARGE FOR INCREASED EMPLOYERS LIABILITY LIMITS				40

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION CO
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-05-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	136,600	.40	546
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.22	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				15
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				561

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
CONNECTICUT

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-06-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	165,899	.52	863
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.25	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				24
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				887

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION DE
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-07-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSON - OUTSIDE	0951	IF ANY	.60	0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION DC
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-08-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	IF ANY	.15	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION FL
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-09-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	1,022,725	.53	5,420
CLERICAL OFFICE EMPLOYEES NOC	8810	240,444	.27	649
INCREASED LIMITS PART TWO 1.4% CODE 9812				85
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				6,154

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
GEORGIA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-10-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	329,479	.32	1,054
CLERICAL OFFICE EMPLOYEES NOC	8810	1,451,373	.16	2,322
INCREASED LIMITS PART TWO 3.3% CODE 9812				111
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				3,487

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
ILLINOIS

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
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Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-12-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	639,581	.62	3,965
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				111
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				4,076

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION IN
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-13-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	235,830	.34	802
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.18	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				22
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				824

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
IOWA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-14-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	IF ANY	.59	0
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.31	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION KS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-15-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	68,085	.44	300
CLERICAL TELECOMMUTER AND EMPLOYEES	8871	94,988	.35	332
INCREASED LIMITS PART TWO 2.8% CODE 9812				18
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				650

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION KY
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-16-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	71,197	.53	377
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.22	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				11
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				388

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION LA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-17-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	835,008	.59	4,927
CLERICAL OFFICE EMPLOYEES NOC	8810	12,687,713	.26	32,988
STORE: DRUG - WHOLESALE	8047	40,912	.99	405
DRUG MEDICINE OR PHARMACEUTICAL PREP. NO MFG. OF INGREDIENTS	4611	2,124,294	1.28	27,191
STORE: DRUG RETAIL	8045	256,685	.74	1,899
INCREASED LIMITS PART TWO 2.8% CODE 9812				1,887
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				69,297

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION MD
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-19-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	113,104	.35	396
CLERICAL OFFICE EMPLOYEES NOC	8810	164,688	.17	280
INCREASED LIMITS PART TWO 2.8% CODE 9812				19
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				695

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
MASSACHUSETTS

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-20-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	113,751	.15	171
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.09	0
COMPANY DEVIATION: 0.750 CODE: 9037				43-
INCREASED LIMITS PART TWO 2.0% CODE 9812				3
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				131

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION MI
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-21-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
COLLECTORS, MESSENGERS OR SALESPERSONS, OUTSIDE	8742	197,195	.35	690
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.19	0
INCREASED LIMITS PART TWO 2.0% CODE 9812				14

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
MINNESOTA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

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Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-22-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	IF ANY	.54	0
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.20	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION MS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-23-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	323,019	.73	2,358
CLERICAL OFFICE EMPLOYEES NOC	8810	74,935	.42	315
INCREASED LIMITS PART TWO 2.8% CODE 9812				75
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				2,748

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION MO
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-24-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	689,314	.50	3,447
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.26	0
INCREASED LIMITS PART TWO 1.2% CODE 9812				41
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				3,488

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION NE
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-26-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	76,404	.54	413
INCREASED LIMITS PART TWO 2.8% CODE 9812				12
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				425

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION NV
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-27-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	36,000	.80	288
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.43	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				8
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				296

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NEW HAMPSHIRE

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-28-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	IF ANY	.79	0
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.30	0
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664 NJTIN: 720509664000
Location of Operations
NO SPECIFIC
LOCATION NJ
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-29-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS-OUTSIDE	8742	625,833	.52	3,254
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.24	0
PREMIUM FOR INCREASED LIMITS PART TWO	3.3	CODE 6199		107

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION NM
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-30-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	77,828	.64	498
INCREASED LIMITS PART TWO 2.8% CODE 9812				14
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				512

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION NY
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

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Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-31-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	685,754	.40	2,743
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.19	0
MINIMUM PREMIUM FOR WAIVER	CODE: 0930			250
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				2,993

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NORTH CAROLINA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-32-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	284,338	.56	1,592
INCREASED LIMITS PART TWO 2.8% CODE 9812				45
MINIMUM PREMIUM FOR WAIVER CODE: 0930				100
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				1,737

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NORTH DAKOTA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

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Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-33-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
FLAT CHARGE FOR EMPLOYERS LIABILITY/ VOLUNTARY COMPENSATION COVERAGE IN MONOPOLISTIC FUND STATES	9139	IF ANY		600
INCREASED LIMITS PART TWO 2.8% CODE 9812				17

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
OHIO

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-34-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
FLAT CHARGE FOR EMPLOYERS LIABILITY/ VOLUNTARY COMPENSATION COVERAGE IN MONOPOLISTIC FUND STATES	9139	819,183		600
INCREASED LIMITS PART TWO 2.8% CODE 9812				17

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION OK
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-35-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	388,082	.75	2,911
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.51	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				82
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				2,993

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION OR
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-36-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	158,815	.33	524
INCREASED LIMITS PART TWO 1.1% CODE 9812				6
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				530

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
PENNSYLVANIA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-37-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESMEN (OUTSIDE), COLLECTORS AND MESSENGERS	0951	776,190	.57	4,424
CLERICAL OFFICE EMPLOYEES	0953	IF ANY	.23	0
INCREASED LIMITS PART TWO 3.3% CODE 9812				146
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				4,570

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SOUTH CAROLINA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

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Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-39-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	367,628	.68	2,500
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.35	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				70
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				2,570

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION TN
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-41-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	626,090	.56	3,506
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.29	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				98
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				3,604

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION TX
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0001-42-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS, OR MESSENGERS-OUTSIDE	8742	1,912,964	.29	5,548
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.17	0
INCREASED LIMITS PART TWO 2.0% CODE 9812				111
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				5,659

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION UT
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-43-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	175,202	.30	526
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.16	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				15
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				541

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
VIRGINIA

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-45-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	252,025	.28	706
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.09	0
INCREASED LIMITS PART TWO 3.3% CODE 9812				23
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				729

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
WASHINGTON

Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-46-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
FLAT CHARGE FOR EMPLOYERS LIABILITY/ VOLUNTARY COMPENSATION COVERAGE IN MONOPOLISTIC FUND STATES	9139	154,445		500
INCREASED LIMITS PART TWO 2.8% CODE 9812				14

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
NO SPECIFIC
LOCATION WV
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0001-47-0001
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SALESPERSONS, COLLECTORS OR MESSENGERS-OUTSIDE	8742	143,861	.42	604
CLERICAL OFFICE EMPLOYEES NOC	8810	IF ANY	.24	0
INCREASED LIMITS PART TWO 2.8% CODE 9812				17
TOTAL PREMIUM SUBJECT TO EXPERIENCE MODIFICATION				621

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF ALABAMA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-01-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				750-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				6,749
COMPANY DEVIATION: 0.800				1,350-
SCHEDULE RATE: 0.750				1,350-
TOTAL ESTIMATED STANDARD PREMIUM				4,049
PREMIUM DISCOUNT 8.1%				328-
TERRORISM CHARGE (Rate 0.0200)	Code 9740			170
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0200)	Code 9741			170
TOTAL ESTIMATED PREMIUM				4,061
STATE ESTIMATED CHARGE				4,061

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF ARIZONA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-02-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				156-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				1,403
COMPANY DEVIATION: 0.650				491-
TOTAL ESTIMATED STANDARD PREMIUM				912
PREMIUM DISCOUNT 8.1%				74-
TERRORISM CHARGE	(Rate 0.0100)	Code 9740		33
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0100)	Code 9741		33
TOTAL ESTIMATED PREMIUM				904
STATE ESTIMATED CHARGE				904

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF ARKANSAS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-03-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				124-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				1,113
SCHEDULE RATE: 0.750				278-
TOTAL ESTIMATED STANDARD PREMIUM				835
PREMIUM DISCOUNT 8.1%				68-
TERRORISM CHARGE (Rate 0.0200)	Code 9740			85
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0200)	Code 9741			85
TOTAL ESTIMATED PREMIUM				937
STATE ESTIMATED CHARGE				937

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF CALIFORNIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-04-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
SCHEDULE RATE: 0.500				2,053-
WAIVER OF SUBROGATION	CODE	0930	1.0100	20
TOTAL ESTIMATED STANDARD PREMIUM				2,033
PREMIUM DISCOUNT 8.1%				165-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		96
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0200)	Code 9741		96
TOTAL ESTIMATED PREMIUM				2,060
CIGA SURCHARGE	0.022850	CODE 0175		47
STATE W.C. ADMINISTRATION SURCHARGE	0.009669	CODE 0176		20
STATE FRAUD INVESTIGATION & PROSECUTION SURCHARGE	0.002648	CODE 0177		5
UNINSURED EMPLOYERS FUND SURCHARGE		0.001362	CODE: 0066	3
SUBSEQUENT INJURIES FUND SURCHARGE		0.001255	CODE: 0068	3
OCCUPATIONAL SAFETY & HEALTH FUND SRCHG		0.002350	CODE: 0069	5
LABOR ENFORCEMENT & COMPLIANCE FUND SRCHG		0.002380	CODE: 0077	5
STATE ESTIMATED CHARGE				2,148

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF COLORADO
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-05-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				56-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				505
SCHEDULE RATE: **0.750**				126-
TOTAL ESTIMATED STANDARD PREMIUM				379
PREMIUM DISCOUNT **8.1%**				31-
TERRORISM CHARGE	(Rate **0.0200**)	Code **9740**		27
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate **0.0200**)	Code **9741**		27
TOTAL ESTIMATED PREMIUM				402
STATE ESTIMATED CHARGE				402

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF CONNECTICUT
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-06-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**89-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**798**
SCHEDULE RATE: **0.750**				**200-**
TOTAL ESTIMATED STANDARD PREMIUM				**598**
PREMIUM DISCOUNT **8.1%**				**48-**
TERRORISM CHARGE (Rate **0.0200**)	Code **9740**			**33**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0200**)	Code **9741**			**33**
TOTAL ESTIMATED PREMIUM				**616**
CONNECTICUT W.C. FUND ASSESSMENT **0.019000**				**11**
CONNECTICUT SECOND INJURY FUND PREMIUM SURCHARGE **(0.027500)**				**17**
STATE ESTIMATED CHARGE				**644**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF DELAWARE
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-07-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
TOTAL ESTIMATED STANDARD PREMIUM				0
TERRORISM CHARGE	(Rate **0.0200**)	Code **9740**		0
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate **0.0200**)	Code **9741**		0
TOTAL ESTIMATED PREMIUM				0
STATE ESTIMATED CHARGE				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF DISTRICT OF COLUMBIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-08-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				0
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				0
SCHEDULE RATE: **0.750**				0
TOTAL ESTIMATED STANDARD PREMIUM				0
TERRORISM CHARGE (Rate **0.0500**)	Code **9740**			0
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0100**)	Code **9741**			0
TOTAL ESTIMATED PREMIUM				0
STATE ESTIMATED CHARGE				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF FLORIDA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-09-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				615-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				5,539
TOTAL ESTIMATED STANDARD PREMIUM				5,539
PREMIUM DISCOUNT 8.1%				449-
TERRORISM CHARGE (Rate 0.0200) Code 9740				253
TOTAL ESTIMATED PREMIUM				5,343
NO STATE SURCHARGES APPLICABLE FOR FLORIDA				0
STATE ESTIMATED CHARGE				5,343

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF GEORGIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-10-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**349-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**3,138**
SCHEDULE RATE: **0.851**				**468-**
TOTAL ESTIMATED STANDARD PREMIUM				**2,670**
PREMIUM DISCOUNT **8.1%**				**216-**
WAIVER OF SUBROGATION	CODE	**9724**		**27**
TERRORISM CHARGE	(Rate **0.0100**)	Code **9740**		**178**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate **0.0100**)	Code **9741**		**178**
TOTAL ESTIMATED PREMIUM				**2,837**
STATE ESTIMATED CHARGE				**2,837**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF ILLINOIS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-12-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				408-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				3,668
SCHEDULE RATE: 0.400				2,201-
TOTAL ESTIMATED STANDARD PREMIUM				1,467
PREMIUM DISCOUNT 8.1%				119-
TERRORISM CHARGE	(Rate 0.0400)	Code 9740		256
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0100)	Code 9741		64
TOTAL ESTIMATED PREMIUM				1,668
IL WC OPERATIONS FUND SURCHARGE		0.010100		17
STATE ESTIMATED CHARGE				1,685

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF INDIANA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-13-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				82-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				742
SCHEDULE RATE: 0.500				371-
TOTAL ESTIMATED STANDARD PREMIUM				371
PREMIUM DISCOUNT 8.1%				30-
TERRORISM CHARGE (Rate 0.0200)	Code 9740			47
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0200)	Code 9741			47
TOTAL ESTIMATED PREMIUM				435
INDIANA SECOND INJURY FUND SURCHARGE 0.006600	CODE 0935			3
STATE ESTIMATED CHARGE				438

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF IOWA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-14-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				0
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				0
COMPANY DEVIATION: 0.850				0
SCHEDULE RATE: 0.850				0
TOTAL ESTIMATED STANDARD PREMIUM				0
TERRORISM CHARGE (Rate 0.0200)	Code 9740			0
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0100)	Code 9741			0
TOTAL ESTIMATED PREMIUM				0
STATE ESTIMATED CHARGE				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF KANSAS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-15-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				65-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				585
TOTAL ESTIMATED STANDARD PREMIUM				585
PREMIUM DISCOUNT 8.1%				47-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		33
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0200)	Code 9741		33
TOTAL ESTIMATED PREMIUM				604
STATE ESTIMATED CHARGE				604

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF KENTUCKY
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-16-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				39-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				349
SCHEDULE RATE: 0.750				87-
TOTAL ESTIMATED STANDARD PREMIUM				262
PREMIUM DISCOUNT 8.1%				21-
TERRORISM CHARGE (Rate 0.0200)	Code 9740			14
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0200)	Code 9741			14
TOTAL ESTIMATED PREMIUM				269
KENTUCKY TAX/ASSESSMENT 0.062800				17
STATE ESTIMATED CHARGE				286

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF LOUISIANA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-17-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				6,930-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				62,367
SCHEDULE RATE: 0.750				15,592-
TOTAL ESTIMATED STANDARD PREMIUM				46,775
PREMIUM DISCOUNT 8.1%				3,789-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		3,189
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0200)	Code 9741		3,189
TOTAL ESTIMATED PREMIUM				49,364
STATE ESTIMATED CHARGE				49,364

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MARYLAND
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-19-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				70-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				625
SCHEDULE RATE: 0.750				156-
TOTAL ESTIMATED STANDARD PREMIUM				469
PREMIUM DISCOUNT 8.1%				38-
TERRORISM CHARGE (Rate 0.0300)	Code 9740			83
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0100)	Code 9741			28
TOTAL ESTIMATED PREMIUM				542
STATE ESTIMATED CHARGE				542

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MASSACHUSETTS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-20-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				13-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				118
LOSS CONSTANT				20
TOTAL ESTIMATED STANDARD PREMIUM				138
PREMIUM DISCOUNT **8.1%**				11-
TERRORISM CHARGE (Rate **0.0300**) Code **9740**				34
TOTAL ESTIMATED PREMIUM				161
MASSACHUSETTS ASSESSMENT CHARGE **0.042000**				6
STATE ESTIMATED CHARGE				167

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MICHIGAN
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-21-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
MERIT RATING 0.950 CODE 9887				35-
TOTAL ESTIMATED STANDARD PREMIUM				669
PREMIUM DISCOUNT 8.1%				54-
TERRORISM CHARGE (Rate 0.0100)	Code 9740			20
TOTAL ESTIMATED PREMIUM				635
STATE ESTIMATED CHARGE				635

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MINNESOTA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-22-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				0
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				0
SCHEDULE RATE: **0.600**				0
TOTAL ESTIMATED STANDARD PREMIUM				0
TERRORISM CHARGE (Rate **0.0200**) Code **9740**				0
TOTAL ESTIMATED PREMIUM				0
MINNESOTA SPECIAL COMPENSATION FUND ASSESSMENT	**0.069000**	CODE: **0174**		0
MINNESOTA WCRA ASSESSMENT	**0.012000**	CODE: **0988**		0
STATE ESTIMATED CHARGE				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MISSISSIPPI
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-23-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				275-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				2,473
SCHEDULE RATE: 0.750				618-
TOTAL ESTIMATED STANDARD PREMIUM				1,855
PREMIUM DISCOUNT 8.1%				150-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		80
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0200)	Code 9741		80
TOTAL ESTIMATED PREMIUM				1,865
STATE ESTIMATED CHARGE				1,865

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF MISSOURI
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-24-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				349-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				3,139
SCHEDULE RATE: 0.750				785-
TOTAL ESTIMATED STANDARD PREMIUM				2,354
PREMIUM DISCOUNT 8.1%				191-
TERRORISM CHARGE (Rate 0.0200) Code 9740				138
TOTAL ESTIMATED PREMIUM				2,301
MISSOURI SECOND INJURY FUND SURCHARGE (0.030000)				69
STATE ESTIMATED CHARGE				2,370

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEBRASKA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-26-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				43-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				382
FLEXIBLE RATING ADJUSTMENT 0.600		Code 9658		153-
TOTAL ESTIMATED STANDARD PREMIUM				229
PREMIUM DISCOUNT 8.1%				19-
TERRORISM CHARGE (Rate 0.0200)		Code 9740		15
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0200)		Code 9741		15
TOTAL ESTIMATED PREMIUM				240
STATE ESTIMATED CHARGE				240

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEVADA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-27-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				30-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				266
SCHEDULE RATE: 0.750				67-
TOTAL ESTIMATED STANDARD PREMIUM				199
PREMIUM DISCOUNT 8.1%				16-
TERRORISM CHARGE (Rate 0.0100)	Code 9740			4
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0100)	Code 9741			4
TOTAL ESTIMATED PREMIUM				191
STATE ESTIMATED CHARGE				191

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEW HAMPSHIRE
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-28-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				0
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				0
SCHEDULE RATE: **0.750**				0
TOTAL ESTIMATED STANDARD PREMIUM				0
TERRORISM CHARGE (Rate **0.0200**)	Code **9740**			0
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0200**)	Code **9741**			0
TOTAL ESTIMATED PREMIUM				0
STATE ESTIMATED CHARGE				0

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEW JERSEY
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-29-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
SCHEDULE RATE: **0.800** CODE 9887				**672-**
TOTAL ESTIMATED STANDARD PREMIUM				**2,689**
TERRORISM CHARGE (Rate **0.0300**)	Code **9740**			**188**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0100**)	Code **9741**			**63**
TOTAL ESTIMATED PREMIUM				**2,940**
ESTIMATED 2ND INJURY FUND SURCHARGE **(0.078200)**	CODE 0935			**263**
EST. UNINSURED EMPLYRS. FUND SURCHARGE **(0.001700)**	CODE 0936			**6**
STATE ESTIMATED CHARGE				**3,209**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEW MEXICO
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-30-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Re-muneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				51-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				461
SCHEDULE RATE: 0.850				69-
TOTAL ESTIMATED STANDARD PREMIUM				392
PREMIUM DISCOUNT 8.1%				32-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		16
TOTAL ESTIMATED PREMIUM				376
STATE ESTIMATED CHARGE				376

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NEW YORK
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-31-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**299-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**2,694**
TOTAL ESTIMATED STANDARD PREMIUM				**2,694**
PREMIUM DISCOUNT **10.3%**				**277-**
EXPENSE CONSTANT CHARGE CODE **0900**				**450**
TERRORISM CHARGE (Rate **0.0400**) Code **9740**				**274**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0100**) Code **9741**				**69**
TOTAL ESTIMATED PREMIUM				**3,210**
NEW YORK STATE ASSESSMENT **0.202000** Code: **0932**				**613**
NEW YORK SECURITY FUND SURCHARGE **0.0000** Code 9749				**0**
STATE ESTIMATED CHARGE				**3,823**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NORTH CAROLINA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-32-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				174-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				1,563
SCHEDULE RATE: 0.600				625-
TOTAL ESTIMATED STANDARD PREMIUM				938
PREMIUM DISCOUNT 8.1%				76-
TERRORISM CHARGE (Rate 0.0150)	Code 9740			43
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0150)	Code 9741			43
TOTAL ESTIMATED PREMIUM				948
STATE ESTIMATED CHARGE				948

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF NORTH DAKOTA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-33-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
TOTAL ESTIMATED STANDARD PREMIUM				617
TOTAL ESTIMATED PREMIUM				617
STATE ESTIMATED CHARGE				617

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF OHIO
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

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ITEM 4 - SCHEDULE NUMBER: 0000-34-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
TOTAL ESTIMATED STANDARD PREMIUM				617
TOTAL ESTIMATED PREMIUM				617
STATE ESTIMATED CHARGE				617

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF OKLAHOMA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-35-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				299-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				2,694
SCHEDULE RATE: 0.750				674-
TOTAL ESTIMATED STANDARD PREMIUM				2,020
PREMIUM DISCOUNT 8.1%				164-
TERRORISM CHARGE	(Rate 0.0200)	Code 9740		78
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0200)	Code 9741		78
TOTAL ESTIMATED PREMIUM				2,012
STATE ESTIMATED CHARGE				2,012

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF OREGON
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-36-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**53-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**477**
TOTAL ESTIMATED STANDARD PREMIUM				**477**
PREMIUM DISCOUNT **8.1%**				**39-**
TERRORISM CHARGE (Rate **0.0200**)	Code **9740**			**32**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0200**)	Code **9741**			**32**
TOTAL ESTIMATED PREMIUM				**502**
OREGON TOTAL ESTIMATED ASSESSMENT **0.062000**				**31**
STATE ESTIMATED CHARGE				**533**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF PENNSYLVANIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-37-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.863000**				**626-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**3,944**
SCHEDULE RATE: **0.750** CODE 9887				**986-**
TOTAL ESTIMATED STANDARD PREMIUM				**2,958**
PREMIUM DISCOUNT **8.1%**				**240-**
TERRORISM CHARGE (Rate **0.0300**)	Code **9740**			**233**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0100**)	Code **9741**			**78**
TOTAL ESTIMATED PREMIUM				**3,029**
PENNSYLVANIA EMPLOYER ASSESSMENTS **0.022500**	CODE **0938**			**68**
STATE ESTIMATED CHARGE				**3,097**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF SOUTH CAROLINA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-39-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**257-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**2,313**
SCHEDULE RATE: **0.750**				**578-**
TOTAL ESTIMATED STANDARD PREMIUM				**1,735**
PREMIUM DISCOUNT **8.1%**				**141-**
TERRORISM CHARGE (Rate **0.0200**)	Code **9740**			**74**
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate **0.0200**)	Code **9741**			**74**
TOTAL ESTIMATED PREMIUM				**1,742**
STATE ESTIMATED CHARGE				**1,742**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF TENNESSEE
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-41-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				360-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				3,244
SCHEDULE RATE: 0.750				811-
TOTAL ESTIMATED STANDARD PREMIUM				2,433
PREMIUM DISCOUNT 8.1%				197-
TERRORISM CHARGE	(Rate 0.0100)	Code 9740		63
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate 0.0300)	Code 9741		188
TOTAL ESTIMATED PREMIUM				2,487
STATE ESTIMATED CHARGE				2,487

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF TEXAS
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-42-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				566-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				5,093
SCHEDULE RATE: 0.633				1,869-
WAIVER OF SUBROGATION	CODE	0930	1.0200	64
TOTAL ESTIMATED STANDARD PREMIUM				3,288
PREMIUM DISCOUNT 8.0%				263-
TERRORISM CHARGE	(Rate 0.0240)	Code 9740		459
TOTAL ESTIMATED PREMIUM				3,484
STATE ESTIMATED CHARGE				3,484

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF UTAH
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-43-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				54-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				487
SCHEDULE RATE: **0.750**				122-
TOTAL ESTIMATED STANDARD PREMIUM				365
PREMIUM DISCOUNT **8.1%**				30-
TERRORISM CHARGE	(Rate **0.0100**)	Code **9740**		18
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM)	(Rate **0.0100**)	Code **9741**		18
TOTAL ESTIMATED PREMIUM				371
STATE ESTIMATED CHARGE				371

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF VIRGINIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-45-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: **0.900000**				**73-**
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				**656**
SCHEDULE RATE: **0.850**				**98-**
TOTAL ESTIMATED STANDARD PREMIUM				**558**
PREMIUM DISCOUNT **8.1%**				**45-**
TERRORISM CHARGE	(Rate **0.0300**)	Code **9740**		**76**
TOTAL ESTIMATED PREMIUM				**589**
STATE ESTIMATED CHARGE				**589**

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF WASHINGTON
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-46-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
TOTAL ESTIMATED STANDARD PREMIUM				514
TOTAL ESTIMATED PREMIUM				514
STATE ESTIMATED CHARGE				514

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028

CHUBB

Name of Insured
PAMLAB INC.

FEIN 720509664
Location of Operations
SUMMARY OF ALL INSUREDS/LOCATIONS
IN THE STATE OF WEST VIRGINIA
Producer Name
STONE INSURANCE, INC.
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY
Endorsement Number

EXTENSION OF INFORMATION PAGE

ITEM 4 - SCHEDULE NUMBER: 0000-47-0000
(INSD-ST-LOC)

Classification of Operations	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per $100 of Remuneration	Estimated Annual Premium
APPLICABLE EXPERIENCE MODIFICATION: 0.900000				62-
PREMIUM ADJUSTED BY APPLICATION OF EXPERIENCE MODIFICATION				559
SCHEDULE RATE: 0.750				140-
TOTAL ESTIMATED STANDARD PREMIUM				419
PREMIUM DISCOUNT 8.1%				34-
TERRORISM CHARGE (Rate 0.0200)	Code 9740			29
CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) (Rate 0.0100)	Code 9741			14
TOTAL ESTIMATED PREMIUM				428
WV DEBT REDUCTION SURCHARGE (0.090000)				38
WV REGULATORY SURCHARGE (0.055000)				23
WV FIRE & CASUALTY SURCHARGE (0.005500)				0
STATE ESTIMATED CHARGE				489

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD

028

CHUBB

Name & Mailing Address of the Insured
PAMLAB INC.

P.O. BOX 8950
MANDEVILLE LA 70470
FEIN 720509664

Name & Address of the Producer
STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471
Producer Number 2-24843 000

Attached to and Forming Part of
Policy Number (13)7575-25-17

Policy Period 08/19/12 **to** 08/19/13

Effective Date 08/19/12

Name of Company
CHUBB INDEMNITY INSURANCE COMPANY

Endorsement Number

INSTALLMENT ENDORSEMENT

It is agreed that the premium on this policy is payable on installment as follows:

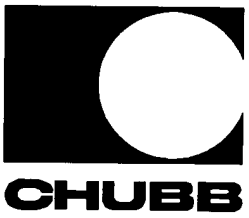
DATE DUE	AMOUNT DUE	
08/19/12	$26,095.25	DEPOSIT
11/19/12	$24,825.25	
02/19/13	$24,825.25	
05/19/13	$24,825.25	

0% COMMISSIONS ON TAXES AND SURCHARGES.

All Other Terms and Conditions Remain Unchanged

Authorized Representative

Issue Date 09/12/12 HOU CLD 028



WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

08 02 0109 (Ed. 4-84)

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

QUICK REFERENCE

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

PLEASE READ YOUR WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY CAREFULLY.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

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

GENERAL SECTION

A. **The Policy**

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

B. **Who is Insured**

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

C. **Workers Compensation Law**

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

D. **State**

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

E. **Locations**

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

PART ONE—WORKERS COMPENSATION INSURANCE

A. **How This Insurance Applies**

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

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

B. **We Will Pay**

We will pay promptly when due the benefits required of you by the Workers Compensation Law.

C. **We Will Defend**

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits. We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. **We Will Also Pay**

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

1. reasonable expenses incurred at our request,

but not loss of earnings;

2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgement as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. **Other Insurance**

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

F. **Payments You Must Make**

You are responsible for any payments in excess of the benefits regularly provided by the Workers Compensation Law including those required because:

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

If we make any payments in excess of the benefits regularly provided by the Workers Compensation Law on your behalf, you will reimburse us promptly.

G. **Recovery From Others**

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

H. **Statutory Provisions**

These statements apply where they are required by law.

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

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

PART TWO—EMPLOYERS LIABILITY INSURANCE

A. **How This Insurance Applies**

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

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

incidental to your work in a state or territory listed in Item 3.A. of the Information Page.

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

B. **We Will Pay**

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

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

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee;

provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. **Exclusions**

This insurance does not cover:

1. Liability assumed under a contract. The 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 USC Sections 901-950), the Non-appropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a.), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws;
9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51- 60), 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;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) 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 benefits 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 of self-insurance is exhausted, the shares of all remaining 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 or storing and retrieving data. We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX —CONDITIONS

A. **Inspection**

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

B. **Long Term Policy**

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

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

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

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

D. **Cancelation**

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the 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 conflicts 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**

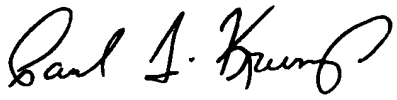
The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

In Witness Whereof, the company issuing this policy has caused this policy to be signed by its authorized representatives, but this policy shall not be valid unless also signed by a duly authorized representative of the company.

CHUBB INDEMNITY INSURANCE COMPANY

Secretary

President



WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 131
(3-85)

WC 00 04 06 (Ed. 3-85)

PREMIUM DISCOUNT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 Standard Premium**
NEW YORK	**2,694**
TEXAS	**3,288**

2. Average percentage discount: 7.8 %

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:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 06A (Ed. 8/95)

PREMIUM DISCOUNT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Schedule

1. **State** — **Estimated Standard Premium**

ALABAMA	4,049
ARIZONA	912
ARKANSAS	835
CALIFORNIA	2,033
COLORADO	379
CONNECTICUT	598
FLORIDA	5,539
GEORGIA	2,670
ILLINOIS	1,467
INDIANA	371
KANSAS	585
KENTUCKY	262
LOUISIANA	46,775
MARYLAND	469

2. Average percentage discount: 7.8 %
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:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 06A (Ed. 8/95)

PREMIUM DISCOUNT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Schedule

1. **State** — **Estimated Standard Premium**

MASSACHUSETTS	138
MICHIGAN	669
MISSISSIPPI	1,855
MISSOURI	2,354
NEBRASKA	229
NEVADA	199
NEW MEXICO	392
NORTH CAROLINA	938
OKLAHOMA	2,020
OREGON	477
PENNSYLVANIA	2,958
SOUTH CAROLINA	1,735
TENNESSEE	2,433
UTAH	365

2. Average percentage discount: 7.8 %
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:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 06A (Ed. 8/95)

PREMIUM DISCOUNT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Schedule

1. **State**	**Estimated Standard Premium**
VIRGINIA	**558**
WEST VIRGINIA	**419**

2. Average percentage discount: 7.8 %
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:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 21 C (Ed. 9-08)

CATASTROPHE (OTHER THAN CERTIFIED ACTS OF TERRORISM) PREMIUM ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 A), 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 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
ALABAMA	0.020000	170
ARIZONA	0.010000	33
ARKANSAS	0.020000	85
CALIFORNIA	0.020000	96
COLORADO	0.020000	27
CONNECTICUT	0.020000	33
DELAWARE	0.020000	0
DISTRICT OF COLUMBIA	0.010000	0
GEORGIA	0.010000	178
ILLINOIS	0.010000	64
INDIANA	0.020000	47
IOWA	0.010000	0
KANSAS	0.020000	33
KENTUCKY	0.020000	14
LOUISIANA	0.020000	3,189
MARYLAND	0.010000	28
MISSISSIPPI	0.020000	80
NEBRASKA	0.020000	15
NEVADA	0.010000	4
NEW HAMPSHIRE	0.020000	0
NEW JERSEY	0.010000	63
NEW YORK	0.010000	69
NORTH CAROLINA	0.015000	43
OKLAHOMA	0.020000	78
OREGON	0.020000	32
PENNSYLVANIA	0.010000	78
SOUTH CAROLINA	0.020000	74
TENNESSEE	0.030000	188
UTAH	0.010000	18
WEST VIRGINIA	0.010000	14

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 22 A (Ed. 9-08)

TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT DISCLOSURE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended and extended by the Terrorism Risk Insurance Program Reauthorization Act of 2007. It serves to notify you of certain limitations under the Act, and that your insurance carrier is charging premium for loss 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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, 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, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premiums, over the calendar year immediately preceding the applicable Program Year.

"Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed $100,000,000,000 in a Program 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 exceed $100,000,000 in a Program Year, the United States Government would pay 85% 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
ALABAMA	0.0200	170
ARIZONA	0.0100	33
ARKANSAS	0.0200	85
CALIFORNIA	0.0200	96
COLORADO	0.0200	27
CONNECTICUT	0.0200	33
DELAWARE	0.0200	0
DISTRICT OF COLUMBIA	0.0500	0
GEORGIA	0.0100	178
ILLINOIS	0.0400	256
INDIANA	0.0200	47
IOWA	0.0200	0
KANSAS	0.0200	33
KENTUCKY	0.0200	14
LOUISIANA	0.0200	3,189
MARYLAND	0.0300	83
MASSACHUSETTS	0.0300	34
MICHIGAN	0.0100	20
MINNESOTA	0.0200	0
MISSISSIPPI	0.0200	80
MISSOURI	0.0200	138
NEBRASKA	0.0200	15
NEVADA	0.0100	4
NEW HAMPSHIRE	0.0200	0
NEW JERSEY	0.0300	188
NEW MEXICO	0.0200	16
NEW YORK	0.0400	274
NORTH CAROLINA	0.0150	43
OKLAHOMA	0.0200	78
OREGON	0.0200	32
PENNSYLVANIA	0.0300	233
SOUTH CAROLINA	0.0200	74
TENNESSEE	0.0100	63
UTAH	0.0100	18
VIRGINIA	0.0300	76

Schedule *(Continued)*

State	Rate	Premium
WEST VIRGINIA	0.0200	29

WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 04 19 (Ed. 1-01)

PREMIUM DUE DATE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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**.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 00 03 03 C (Ed. 10-04)

EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement applies only to work in the states shown in the Schedule.

A. Part One (Workers Compensation Insurance) does not apply to work in a state shown in the Schedule.

B. Part Two (Employers Liability Insurance) applies to work in states shown in the Schedule as though they were shown in Item 3.A. of the Information Page.

C. Part Two (Employers Liability Insurance), C. Exclusions is changed by adding these exclusions.

This insurance does not cover:

13. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers compensation law of any state shown in the Schedule or otherwise fail to comply with that law.

Schedule

States

NORTH DAKOTA
WASHINGTON

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 124
(4-84)

WC 00 03 13

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.*

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

Schedule

AS PER WRITTEN CONTRACT

WC 99 03 04 (Ed. 7-08)

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT—CALIFORNIA

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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. The additional premium for the blanket waiver offered by this endorsement shall be 1.00 % of total California premium.

Schedule

Person or Organization	Job Description
BLANKET WAIVER - ANY PERSON OR ORGANIZATION FOR WHOMTHE NAMED INSURED HAS AGREED BY WRITTEN CONTRACT TO FURNISH THIS WAIVER	ALL CALIFORNIA OPERATIONS

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 369
(7-90)

WC 00 04 14 (Ed. 7-90)

NOTIFICATION OF CHANGE IN OWNERSHIP ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

"This endorsement is not applicable in California."

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 330
(5-86)

WC 02 06 01 (Ed. 5-86)

ARIZONA CANCELATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

The Cancelation Condition of the policy is replaced by this Condition:

D. Cancelation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take effect.
2. We may cancel this policy if you fail to pay premium when due. We must mail or deliver to you and the Industrial Commission of Arizona not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing that notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancelation notice.

WC 262a
(4-92)

WC 03 06 01 A (Ed. 4-92)

ARKANSAS AMENDATORY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Part Two—Employers' Liability Insurance

C. Exclusions

2. Is replaced by:

punitive or exemplary damages because of bodily injury to an employee employed in violation of law; punitive or exemplary damages are defined by Arkansas Bulletin No. 4-82 as those damages which are imposed to punish a wrongdoer and to deter others from similar conduct;

Part Six—Conditions

D. Cancelation is replaced by:

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancelation is to take affect.

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 and to the Arkansas Workers Compensation Commission not less than 10 days advance written notice stating when the cancelation is to take effect. If we cancel for any other reason, we will mail or deliver to you and to the Arkansas Workers Compensation Commission not less than 30 days advance written notice stating when the cancelation is to take effect. Mailing notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient notice.

3. The policy period will end on the day and hour stated in the cancelation notice.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 385
(11-90)

WC 05 04 02 (Ed. 11-90)

COLORADO CLASSIFICATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WC 199
(4-84)

WC 06 03 01

CONNECTICUT APPLICATION OF WORKERS' COMPENSATION INSURANCE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 06 03 03 C (Ed. 7-11)

CONNECTICUT WORKERS COMPENSATION FUNDS ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 06 06 01 (Ed. 1-03)

CONNECTICUT NONRENEWAL ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Add the following to **Part Six – Conditions** of the policy:

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 via registered mail, certified mail or by mail evidenced by a certificate of mailing, or deliver to the named insured at the address shown in the policy, at least sixty (60) days advance notice of our intention not to renew.

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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 358
(7-88)

WC 07 06 01

DELAWARE NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

We may elect not to renew the policy. By certified mail 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 263
(4-84)

WC 08 06 01

DISTRICT OF COLUMBIA CANCELATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 Cancelation Condition of the policy is replaced by this Condition:

D. Cancelation

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation 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 cancelation 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 cancelation notice.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 09 03 03 (Ed. 8-05)

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the date issued unless otherwise stated.
(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WC 09 06 06 (Ed. 10-98)

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 titled 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 10 06 01-A (Ed. 4-93)

GEORGIA CANCELATION, NONRENEWAL AND CHANGE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

The Cancelation Condition of the policy is replaced by this Condition:

D. **Cancelation, Nonrenewal and Change**

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect, subject to the following:

   a. If only your interest is affected, the effective date of cancelation 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 canceled 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 practicable after receiving your request for cancelation.

      Our notice will state the effective date of cancelation, 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 cancelation 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 cancelation 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 to you a notice of cancelation or nonrenewal by certified mail, return receipt requested, to your last address of record at least 75 days prior to the effective date of cancelation or nonrenewal.

3. If we increase current policy premium by more than 15% (other than any increase due to change in risk, exposure or experience modification or resulting from an audit of auditable coverages), limit or restrict coverage, we must mail by first class mail or deliver a notice of our action (including dollar amount of any increase in renewal premium more than 15%) to you at the last mailing address of record at least 45 days before the expiration date of this policy.

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

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

ILLINOIS AMENDATORY ENDORSEMENT

WC 12 06 01 D (Ed. 7-11)

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

Part Six (Conditions), Condition A. **Inspection**, Condition D. **Cancellation** and Condition E. **Sole Representative** of the policy are replaced by these four Conditions.

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

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 and to the broker or the agent of record advance written notice stating when the cancellation is to take effect.
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 more than 60 days.
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 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 Director has determined that we no longer have adequate reinsurance to meet our needs.

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 canceling.

6. 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. If we fail to give 60 days notice, the policy will automatically be extended for one year. Mailing that notice to you at your last known mailing address will be sufficient to prove notice. An exact and unaltered copy of such notice shall also be sent to the insured's broker, if known, or the agent of record at the last mailing address known by the company.

2. Our notice of nonrenewal will state our reasons for not renewing.

3. 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 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.

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 to give us notice of cancellation.

Part Five (Premium), Section G. **Audit** is replaced by this Section.

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 15 04 01A (Ed. 1-10)

KANSAS FINAL PREMIUM ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 152a
(1-87)

WC 15 06 01 A

KANSAS CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

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

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us stating when the cancelation 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 cancelation 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 cancelation 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 cancelation will state our reasons for canceling.
5. The policy period will end on the day and hour stated in the cancelation 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 16 03 05 (Ed. 6-07)

KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

This endorsement modifies the insurance policy to which it is attached and applies to the insurance provided by this policy because Kentucky is shown in Item 3.A. of the Information Page.

F.3. of Part One, Workers Compensation Insurance of the policy is replaced by the following:

F. **Payments You Must Make**

3. you fail to comply with a health or safety law or regulation; provided that, however, we are responsible for payment of any amounts in excess of the benefits regularly provided under the workers compensation law of this state if an accident is caused in any degree by the intentional failure of the employer to comply with any specific statute or lawful administrative regulation made thereunder, communicated to the employer and relative to the installation or maintenance of safety appliances or methods as provided in KRS 342.165(1); or

Except for any payments for which we are responsible as provided in Section F.3. above, 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 16 06 02 (Ed. 10-99)

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

NOTICE OF YOUR RIGHTS

If you believe that the rates or the rating system under this policy have been incorrectly or improperly applied, you may request a review of the manner in which the rate or rating system has been applied You must make your request in writing to us or the National Council on Compensation Insurance, Inc. (NCCI). We or NCCI has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, we or NCCI shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of your review. Your appeal is to be sent to

Legal Division

Department of Insurance

P.O. Box 517

Frankfort, KY 40602

Your request for an appeal should include a statement of the facts and how the rates or rating system were incorrectly or improperly applied. Also, enclose copies of the results of the review and any other correspondence from us or NCCI. If your appeal shows good cause, the commissioner shall hold a hearing. The commissioner may, after the hearing, issue a final order affirming, modifying or reversing our or NCCI's action.

Notes:

1. This notice is required on new and renewal policies.
2. If the policy is a new policy, the notice shall be provided with the policy.
3. If the policy is renewed, the notice shall be provided at time of renewal.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 17 03 03

LOUISIANA DUTY TO DEFEND ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement applies only 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 – Employer's 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 17 06 01 E (Rev. 11-11)

LOUISIANA AMENDATORY ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

PART FIVE–PREMIUM

Section E., Final Premium of Part Five (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 SIX–CONDITIONS

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

D. **Cancellation**

1. If coverage has not been in effect for sixty days and the policy is not a renewal, cancellation shall be effected by mailing or delivering a written notice to the first-named insured at the mailing address shown on the policy at least sixty days before the cancellation effective date, except in cases where cancellation based on nonpayment of premium. Notice of cancellation based on nonpayment of premium shall be mailed or delivered at least ten days prior to the effective date of cancellation. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, no insurer shall cancel a 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 or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.
   c. Activities or omissions on the part of the named insured which change or increase any hazard insured against, including a failure to comply with loss control recommendations.

d. Change in the risk which 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 the continuation of the policy would jeopardize a company's solvency or would place the insurer 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. a. A notice of cancellation of insurance coverage by an insurer shall be in writing and shall be mailed or delivered to the first-named insured at the mailing address as shown on the policy. Notices of cancellation based on conditions 1.b. through 1.g. above shall be mailed or delivered at least thirty days prior to the effective date of the cancellation; notices of cancellations based upon condition 1.a. above shall be mailed or delivered at least ten days prior to the effective date of cancellation. The notice shall state the effective date of the cancellation.

b. The insurer shall provide the first-named insured with a written statement setting forth the reason for the cancellation where the insured requests such a statement in writing and the named insured agrees in writing to hold the insurer harmless from liability for any communication giving notice of or specifying the reasons for a cancellation or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for cancellation under this endorsement.

3. Nothing in this endorsement shall require an insurer to provide a notice of cancellation or a statement of reasons for cancellation where cancellation for nonpayment of premium is effected by a premium finance agency or other entity pursuant to a power of attorney or other agreement executed by or on behalf of the insured.

4. An insurer may decide not to renew a policy if it delivers or mails to the first-named insured at the address shown on the policy written notice it will not renew the policy. Such notice of nonrenewal shall be mailed or delivered at least sixty days before the expiration date. Such notice to the insured shall include the insured's 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 less than sixty days before expiration, coverage shall remain in effect under the same terms and conditions until sixty days after notice is mailed or delivered. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this endorsement, the transfer of a policyholder between companies within the same insurance group shall 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 shall not be refusals to renew.

5. Notice of nonrenewal shall not be required if the insurer or a company within the same insurance group has offered to issue a renewal policy, or where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

6. If an insurer provides the notice described in paragraph 4 above and thereafter the insurer extends the policy for ninety days or less, an additional notice of nonrenewal is not required with respect to the extension.

7. An insurer shall mail or deliver to the named insured at the mailing address shown on the policy written notice of any rate increase, change in deductible, or reduction in limits or coverage at least thirty days prior to the expiration date of the policy. If the insurer fails to provide such thirty-day notice, the coverage provided to the named insured at the expiring policy's rate, terms, and conditions shall remain in effect until notice is given or until the effective date of replacement coverage obtained by the named insured, whichever first occurs. For the purposes of this paragraph, notice is considered given thirty days following date of mailing or delivery of the notice. If the insured elects not to renew, any earned premium for the period of extension of the terminated policy shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, the premium increase, if any, and other changes shall be effective the day following the prior policy's expiration or anniversary date.

8. Paragraph 7 shall not apply to the following:

   a. Changes in a rate or plan filed with the insurance rating commission and applicable to an entire class of business.

   b. Changes based upon the altered nature or extent of the risk insured.

   c. Changes in policy forms filed and approved with the commissioner and applicable to an entire class of business.

   d. Changes requested by the insured.

9. Proof of mailing of notice of cancellation, or of nonrenewal or of premium or coverage changes, to the named insured at the address shown in the policy, shall be sufficient proof of notice.

Section I., **Actions Against Us**, of Part Two (Employers Liability Insurance) 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.

This Condition is added to the policy:

Your Right to Remove Agent

We will not change or remove the agent of record who wrote this policy prior to 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 15 days in advance of 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

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 17 06 02 A (Ed. 2-96)

LOUISIANA COST CONTAINMENT ACT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 19 06 01 E (Ed. 1-09)

MARYLAND CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement applies only to the insurance provided by the policy because Maryland 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. You will mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel or nonrenew this policy as follows:
   a. If the policy is cancelled for nonpayment of premium, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve you by certificate of mailing, not less than ten (10) days advance written notice stating when the cancellation will take effect.
   b. If the policy is cancelled for reasons other than nonpayment of premium or if the policy is nonrenewed, we will file with the Office of the Maryland Workers Compensation Commission's designee, and serve by certified mail or personal service upon you, not less than thirty (30) days advance written notice stating when the cancellation or nonrenewal will take effect.

   Mailing this notice by certified mail to you at your mailing address last known to us creates a presumption of actual delivery of notice. You may be able to rebut this presumption by providing evidence that the notice was not delivered.
3. The effective dates of cancellation or nonrenewal are determined as follows:
   a. Except for cancellation for non-payment of premium, the policy period will end on the day and hour stated in the cancellation or nonrenewal notice, or 30 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.
   b. For cancellation for non-payment of premium, the policy period will end on the day and hour stated in the cancellation notice, or 10 days after the date the notice is received by the Maryland Workers Compensation Commission's designee, whichever date is later.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 22 00 00 A (Ed. 11-03)

MINNESOTA AMENDATORY ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

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 postjudgement interest assuming that the principal amount of that judgement 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 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 — Employer's 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.

WC 24 06 01 B (Ed. 1-96)

MISSOURI CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

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

Cancelation

1. You may cancel this policy. You will mail or deliver advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will mail or deliver to you not less than 60 days advance written notice stating when the cancelation is to take effect and our reason for cancelation. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. The 60-day notice requirement does not apply where cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;
   c. a violation of policy terms;
   d. changes in conditions after the effective date of the policy materially increasing the hazards originally insured;
   e. our insolvency;
   f. our involuntary loss of reinsurance for the policy.
4. The policy period will end on the day and hour stated in the cancelation notice.

Nonrenewal

1. We may elect not to renew the policy. We will mail to you not less than 60 days advance written notice stating when the nonrenewal will take effect and our reason for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
2. If we fail to provide the notice of nonrenewal as required, the policy will still terminate on its expiration date if:
   a. we show you our willingness to renew the policy but 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 24 06 04 (Ed. 7-99)

MISSOURI AMENDATORY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

Section G., **Audit**, of Part Five (Premium) 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 during regular business hours during and after the policy period ends. These record include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. Information developed by audit will be used to determining final premium. Insurance rate service organizations have the same rights we have under this provision.

Audits shall be completed, billed, and premiums returned within 120 days of policy expiration or cancelation. This standard of 120 days shall not be applicable if:

1. A delay is caused by your failure to respond to reasonable audit requests provided that the requests are timely and adequately documented; or
2. A delay is by the mutual agreement of you and us provided that the agreement is adequately documented.

If you or we have any objection to the results of any audit, you or we shall have up to three years from the date of expiration or cancelation of this policy in which to send a written notice demanding a reconsideration of the audit. The written notice shall be based upon sufficiently clear and specific facts as to why the audit should be reconsidered.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 26 06 01 C (Ed. 7-96)

NEBRASKA CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

1. You may cancel this policy within the policy period by giving notice to us, fixing the date on which the cancelation is to be effective.
2. The notice, from you, is to be sent by certified mail.
3. We are required by Nebraska Law to give notice of your intent to cancel a policy to the Nebraska Workers' Compensation Court.
4. The cancelation shall not be effective until ten (10) days after we give notice to the Nebraska Workers' Compensation Court that the policy is being canceled. However, if you have secured insurance with another insurer, the cancelation will be effective as of the effective date of such other notice of coverage.
5. We may cancel or nonrenew this policy within the policy period by giving notice to you and to the Nebraska Workers' Compensation Court, fixing the date on which the cancelation or nonrenewal is to be effective.
6. The notice from us will contain a brief statement of the reasons for cancelation or nonrenewal and will be sent to you by certified mail.
7. The nonrenewal shall not be effective until thirty (30) days after the giving of notice to you and to the Nebraska Workers' Compensation Court.
8. The cancelation shall not be effective until thirty (30) days after the giving of notice to you and to the Nebraska Workers' Compensation Court, except the cancelation shall be effective ten (10) days after the giving of the notice if the cancelation is based on:
   a. nonpayment of premiums;
   b. failure of the insured to reimburse deductible losses as required under the policy; or
   c. failure of the insured, if covered pursuant to the Assigned Risk Plan, to comply with workplace safety laws found in Nebraska statutes.
9. All notices shall be provided in writing and shall be deemed given upon mailing by certified mail, except that we may give notice to the Nebraska Workers' Compensation Court by approved electronic means. Notice provided to the Nebraska Workers' Compensation Court by approved electronic means shall be deemed given upon receipt.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 28 06 04 (Ed. 4-92)

NEW HAMPSHIRE AMENDATORY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 Cancelation 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 cancelation will take effect 30 days after the termination notice is filed.
4. In case of cancelation for reasons other than nonpayment of premium, cancelation will take effect 45 days after notice of termination is filed.
5. If you have obtained coverage from another insurance carrier or have qualified as a self-insurer, cancelation is effective on the date you obtained the coverage or qualified as a self-insurer.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 29 03 06 B (Ed. 7-07)

NEW JERSEY PART TWO EMPLOYERS LIABILITY ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 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.

The 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 160
(4-84)

WC 30 03 02

NEW MEXICO SAFETY DEVICE EXCLUSION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

Section 52-1-10 of the New Mexico workers' compensation law may make you liable for the payment of additional benefits in the case of bodily injury to employees resulting from your failure to supply safety devices. The policy does not cover these additional benefits.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 161
(4-84)

WC 30 03 03

NEW MEXICO VOLUNTEER WORKER ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement applies to the insurance provided by the Voluntary Compensation Coverage Endorsement in New Mexico.

Voluntary compensation insurance for volunteer firemen, law enforcement officers and hospital workers will be determined on the basis of remuneration normally received by regular employees doing the same or similar work and employed for the same time as the regular employees.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 396
(1-90)

WC 30 06 01 (Ed. 1-90)

NEW MEXICO CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

The Cancelation Condition of this policy is replaced by the following:

Cancelation

You may cancel this policy by returning it to us or by giving us a written notice and stating at what future time coverage is to cease.

We may cancel this policy, or one or more of its parts, by giving you a written notice. If the premium has not been paid when due, we may cancel at any time by giving the required notice at least 10 days before the cancelation is effective.

If the policy has been in effect less than 60 days and is not a renewal policy, we may cancel by giving the required notice at least 10 days before the cancelation is effective.

If the policy has been in effect for 60 days or more or is a renewal, we may cancel only for one or more of the following reasons:

a. The policy was obtained through material misrepresentation, fraudulent statements, omissions or concealment of fact material to the acceptance of the risk or to the hazard assumed by us;

b. Willful and negligent acts or omissions by the insured have substantially increased the hazards insured against;

c. You presented a claim based on fraud or material misrepresentation; or

d. There has been a substantial change in the risk assumed by us since the policy was issued.

We will give the required Notice of Cancelation stating the reason(s) for cancelation at least 30 days before the cancelation is effective. The notice will state the time that the cancelation is to take effect. The notice will be sent to your mailing address last known to us.

Your return premium, if any, will be calculated as follows:

a. If we cancel, we will return all unearned premiums.

b. If you cancel, the refund will be calculated according to our rules.

Your return premium will be refunded to you with the cancelation notice or within a reasonable time. Payment or tender of the unearned premium is not a condition of cancelation.

Nonrenewal

If we decide not to renew this policy, we must give you written notice of our intention not less than 30 days prior to the expiration of the policy.

This nonrenewal section does not apply to any policy of insurance issued to an insured who has its principal place of business outside this state.

WC 229
(4-84)

WC 31 03 08 (Ed. 4-84)

NEW YORK LIMIT OF LIABILITY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 32 03 01 B (Ed. 10-01)

NORTH CAROLINA AMENDED COVERAGE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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**

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 facultative 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 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 must 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 required to be given by registered or certified mail, cancellation will not be effective unless and until that method is employed and completed. 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, 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 321b
(4-92)

WC 34 03 01 B (Ed. 4-92)

OHIO EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement applies only to work in Ohio.

A. Part One (Workers' Compensation Insurance) does not apply to work in Ohio.

B. Part Two (Employers' Liability Insurance) applies to work in Ohio as though it were shown in Item **3.A.** of the Information Page.

C. Part Two (Employers' Liability Insurance), **C. Exclusions** is changed by adding these exclusions.

C. Exclusions

This insurance does not cover:

5. bodily injury intentionally caused or aggravated by you, or bodily injury resulting from an act which is determined to have been committed by you with the belief that an injury is substantially certain to occur;

13. bodily injury to any member of the flying crew of any aircraft;

14. bodily injury to an employee when you are deprived of common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law of Ohio or otherwise fail to comply with that law.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 35 03 03 (Ed. 12-10)

OKLAHOMA EMPLOYERS LIABILITY INTENTIONAL TORT EXCLUSION ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

_____
Authorized Representative

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;

WC 35 06 01 E (Ed. 7-06)

OKLAHOMA CANCELLATION, NONRENEWAL AND CHANGE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 by you 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 any 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 insured; or
c. Changes in policy forms filed with or approved by the Insurance Commissioner and applicable to an entire class of business.

WC 35 06 04 (Ed. 8-99)

OKLAHOMA ELECTION OF COVERAGE NOTIFICATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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, YOU 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 36 03 06 (Ed. 1-02)

OREGON LIMITS OF LIABILITY ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

The limits of our liability under Part Two of the policy are:

Bodily Injury by Accident	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each accident
Bodily Injury by Disease	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, policy limit
Bodily Injury by Disease	$500,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each employee

This change applies to the insurance this policy provides for Oregon operations only.

WC 36 04 06 (Ed. 10-01)

OREGON PREMIUM DUE DATE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

This endorsement is used to amend:

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

PART FIVE
PREMIUM

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

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

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 36 06 01E (Ed. 1-08)

OREGON CANCELLATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 effect.
3. Mailing notice to you at your last known mailing address will be sufficient to prove notice.
4. The policy period will end at 12:00 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, provided 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 189
(4-84)

WC 37 06 01

SPECIAL PENNSYLVANIA ENDORSEMENT—INSPECTION OF MANUALS

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 434
(4-84)

WC 37 06 02

PENNSYLVANIA NOTICE

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 37 06 04 (Ed. 10-99)

PENNSYLVANIA

EMPLOYER ASSESSMENT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

Act 57 of 1997 requires that "...the assessments for the maintenance of the Subsequent Injury Fund, the Workmen's Compensation Supersedes Fund and the Workmen's Compensation Administration Fund under sections 306.2, 443 and 446 of the act of June 2, 1915 (P.L. 736, No. 338), known as the "Workers' Compensation Act, shall be imposed, collected and remitted through insurers in accordance with regulations promulgated by the Department of Labor and Industry."

EMPLOYER ASSESSMENT FORMULA:

Employer Assessment = Act 547 of 1997 Employer Assessment Factor **X** Employer Assessment Premium Base

Act 57 of 1997 Employer Assessment Factor

A factor expressed to four decimal places proposed by the Pennsylvania Compensation Rating Bureau and approved by the Pennsylvania Insurance Commissioner.

Employer Assessment Premium Base

Calculation of Employer Assessment Premium Base proceeds by adding back to the total policy premium the amount of any Small Deductible Premium Credit or Large Deductible Premium Credit.

Code 0938

EMPLOYER ASSESSMENT FACTOR	EMPLOYER ASSESSMENT
.022500	68

WC 42 04 07 (Ed. 3-02)

TEXAS – AUDIT PREMIUM AND RETROSPECTIVE PREMIUM ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 43 06 02 (Ed. 7-02)

UTAH CANCELLATION ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 mail 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 to 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 489
(7-93)

WC 45 06 02

VIRGINIA AMENDATORY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 cancelation, including the date of and reasons for the cancelation, to the Workers' Compensation Commission.
2. We may cancel this policy. We will provide you with 30 days notice of cancelation. We will provide the Workers' Compensation Commission with immediate notice of such cancelation. 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 cancelation by you or us, you must provide 30 days written notice of the cancelation 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 47 03 01A (Ed. 7-08)

WEST VIRGINIA EMPLOYERS LIABILITY INSURANCE INTENTIONAL ACT EXCLUSION ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

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 which is the result of your engaging in conduct equivalent to an intentional tort, however defined, including by your deliberate intention as that term is defined by W. Va. Code § 23-4-2(d)(2).

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 47 03 02 (Ed. 7-08)

WEST VIRGINIA WORKERS COMPENSATION INSURANCE RECOVERY FROM OTHERS ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

Part One — Workers Compensation Insurance, G. — Recovery From Others, is replaced by the following:

We have your rights 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 47 06 01 (Ed. 7-08)

WEST VIRGINIA CANCELLATION ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

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

Part Six, D (Conditions—Cancellation) is replaced by:

D. **Cancellation**

1. You may cancel this policy. You must mail or deliver advance written notice to us by stating when the cancellation is to take effect.
2. We may cancel this policy at any time by providing you thirty (30) days advance written notice.
3. Not withstanding #2 above, if you fail to pay any premium due or refuse to comply with a premium audit under this policy, we may cancel the policy by providing you ten (10) days advance written notice.
4. We may also choose not to renew this policy by providing sixty (60) days advance written notice.
5. Our mailing of the Notice of Cancellation or Non-Renewal to your mailing address as listed in Item 1 of the information page will be sufficient notice of our intent to cancel. We will also provide notice of the cancellation or non-renewal of the policy to the West Virginia Insurance Commissioner at least ten (10) days prior to the effective date of the termination, within ten (10) days of receipt of your request for cancellation, as applicable.

WC 04 03 60 A (Ed. 11-99)

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT—CALIFORNIA

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 535
(12-93)

WC 04 06 01 A

CALIFORNIA CANCELATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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.** Failure to comply with Federal or State safety orders;
   - **h.** Failure to comply with written recommendations of our designated loss control representatives;
   - **i.** The occurrence of a material change in the ownership of your business;
   - **j.** The occurrence of any change in your business or operations that materially increases the hazard for frequency or severity of loss;
   - **k.** The occurrence of any change in your business or operation that requires additional or different classification for premium calculation;
   - **l.** 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 (**l**), 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. The policy period will end on the day and hour stated in the cancelation notice.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 20 04 05 (Ed. 6-01)

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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

WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE POLICY

WC 20 06 01A (Rev. 7-08)

MASSACHUSETTS CANCELLATION ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 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.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 22 03 01

MINNESOTA COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS

This endorsement changes the policy to which it is attached effective on the inception of the policy unless a different date is indicated below.

This endorsement, effective on 08/19/12 (DATE) at 12:01 a.m. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to: PAMLAB INC.

Endorsement No.

_____
Authorized Representative

Under Part Six – Conditions, the following condition is added:

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

All other terms and conditions remain unchanged.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 09 04 03A (Ed. 1-08)

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement addresses requirements of the Terrorism Risk Insurance Act of 2002 as amended by the Terrorism Risk Insurance Program Reauthorization Act of 2007.

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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.
2. "Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, 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. "Insured Deductible" means, for the period beginning on January 1, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premium, over the calendar year immediately preceding the applicable Program Year.
5. "Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

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 Program 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 exceeds $100,000,000 in a Program Year, the United States Government would pay 85% of our insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that 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
0.0200

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 16 06 01 (Ed. 12-97)

KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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

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

Cancelation

1. You may cancel this policy. You will deliver or mail advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will deliver or mail to you not less than 75 days advance written notice stating when the cancelation is to take effect and our reason or reasons for cancelation. If we cancel for nonpayment of premium or within 60 days of the date of issuance of the policy, we will deliver or mail this notice not less than 14 days prior to the effective date of cancelation. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. After coverage has been in effect more than 60 days or after the effective date of a renewal policy, we may not cancel the policy unless cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. discovery of fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or presenting a claim under the policy;
   c. discovery of willful or reckless acts or omissions on your part increasing any hazard originally insured;
   d. changes in conditions after the effective date of the policy or any renewal substantially increasing any hazard originally insured;
   e. a violation of any local fire, health, safety, building, or construction regulation or ordinance at any of your covered workplaces substantially increasing any hazard originally insured;
   f. our involuntary loss of reinsurance for the policy;
   g. a determination by the commissioner that the continuation of the policy would place us in violation of Kentucky insurance laws.

Nonrenewal

1. We may elect not to renew the policy. We will deliver or mail to you not less than 75 days advance written notice stating our intention not to renew and our reason or reasons for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

2. If we fail to provide the notice of nonrenewal as required, the policy will be deemed to be renewed for the ensuing policy period upon payment of the appropriate premium, and coverage will continue until you have accepted replacement coverage with another insurer, until you have agreed to the nonrenewal, or until the policy is canceled.

3. If we have delivered or mailed to you a renewal notice, bill, certificate, or policy not less than 30 days before the end of the current policy period clearly stating the amount and due date of the renewal premium charge, then the policy will terminate on the due date without further notice unless the renewal premium is received by us or our agent on or before the due date. If the policy terminates in this manner, we will deliver or mail to you within 15 days of termination at your mailing address shown in Item 1 of the Information Page a notice that the policy was not renewed and the date on which coverage ceased to exist. Proof of mailing of the renewal premium to us or our agent on or before the due date will constitute a presumption of receipt on or before the due date.

4. If we offer to renew the policy for a premium amount more than 25% greater than the premium amount for the current policy term for like coverage and like risks, we will deliver or mail to you and to your agent not less than 75 days advance written notice of the renewal premium amount. We may at our option, in order to comply with this requirement, extend the period of coverage of the current policy at the expiring premium.

WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE POLICY

WC 20 03 03D (Rev. 8-10)

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 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 if 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
HOUSTON
2800 POST OAK BLVD
SUITE 2400
HOUSTON, TX 77056-6118

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

WC 22 06 01 D (Ed. 8-06)

MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 canceled, 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.

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

Notes:

1. In order to conform each carriers' information page with other provisions of the Standard Workers' Compensation Policy, the Information Page must, at a minimum, comply with the sequence of Items 1 through 4 of WC 00 00 01 which may not be changed.

2. This endorsement conforms to the minimum notice requirements of Minnesota Statutes 60A.36, 60A.37 and 176.185, subd.1 and 1a. An insurer may modify this endorsement to provide for notice periods that exceed the statutory minimums.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 27 06 01C (Ed. 10-08)

NEVADA CANCELLATION AND NONRENEWAL ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 or 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 you with 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 you with 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 the 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 31 03 19F (Rev. 2-11)

NEW YORK CONSTRUCTION CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM EXPLANATORY ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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.

The declarations section of this policy will show a credit of 0.00% if you are not eligible for this credit, or if you are eligible for this credit and have not yet applied for a credit. Credits are earned for average wages in excess of $15.50 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	6260	7601	9549
5022	5184	5402	5479	5545	5703	6216	6306	7855	9553
5037	5188	5403	5480	5547	5709	6217	6319	8227	
5040	5190	5428							

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 the third quarter, as reported to taxing authorities, for the year preceding the policy date. Total payroll is to continue to be reported for employees engaged in the construction of one or two-family residential housing. For example:

POLICY EFFECTIVE DATE	THIRD QUARTER PAYROLL
4/1/09 thru 3/31/10	2008
4/1/10 thru 3/31/11	2009
4/1/11 thru 3/31/12	2010
4/1/12 thru 3/31/13	2011
4/1/13 thru 3/31/14	2012
4/1/14 thru 3/31/15	2013

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 nine 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.

Credits are calculated by the New York Compensation Insurance Rating Board. You must submit a completed application to: Attention: Field Services Department, New York Compensation Insurance Rating Board, 733 Third Avenue, New York, New York 10017.

Applications 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 policy effective and expiration date, however, it must be accompanied by a letter stating the reason for the delay. Under no circumstances will an application be accepted for any policy if it is received after the expiration date of the policy. For short-term policies the application must be received prior to the expiration date of the short-term policy. If it is received after the policy expiration, no credit will be calculated.

The New York Workers Compensation and Employers Liability Insurance Manual, and not this endorsement, govern the implementation and use of the NYCCPAP.

For online entry of the information requested on this form refer to: http://cpap.nycirb.org/

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 37 06 03A (Ed. 8-95)

PENNSYLVANIA ACT 86-1986 ENDORSEMENT
NONRENEWAL, NOTICE OF INCREASE OF PREMIUM, and RETURN OF UNEARNED PREMIUM

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 cancelation.
   b. If you cancel, the unearned premium will be returned within 30 days after the effective date of cancelation.

over

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 1.a. and 1.b. 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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 99 01 01 (Ed. 1-08)

TEXAS TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 2007.

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 resulting from the Terrorism Risk Insurance Program Reauthorization Act of 2007.

"Act of Terrorism" means any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State, 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 (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, 2008, and ending on December 31, 2014, an amount equal to 20% of our direct earned premium, over the calendar year immediately preceding the applicable Program Year.

"Program Year" refers to each calendar year between January 1, 2008 and December 31, 2014, as applicable.

Limitation of Liability

The Act limits our liability to you under this policy. If aggregate Insured Losses exceed $100,000,000,000 in a Program 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 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 exceeds $100,000,000 in a Program Year, the United States Government would pay 85% 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 charged for the coverage for Insured Losses under this policy is included in the amounts shown in Item 4 of the Information Page or in the Schedule in the Texas Terrorism Premium Endorsement (WC 99 04 01), attached to this policy.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 99 04 01 (Ed. 1-08)

TEXAS TERRORISM PREMIUM ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

This endorsement is notification 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.

For purposes of this endorsement, an "act of terrorism" is defined as:

a. Any act that is violent or dangerous to human life, property or infrastructure; and
b. 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.

The premium charge for the coverage your policy provides for workers compensation losses caused by an act of terrorism is shown in Item 4 of the Information Page or in the Schedule below.

Schedule

State	Rate per $100 of payroll
TEXAS	0.0240

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

08 02 0259

COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS
(WC 99 03 03)

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

Under Part Six – Conditions, the following condition is added:

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

All other terms and conditions remain unchanged.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 42 03 04 A (Ed. 1-00)

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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. ( ) Specific 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 2.00 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:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 42 03 01 F (Ed. 1-00)

TEXAS AMENDATORY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

Authorized Representative

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 rate 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. **Cancelation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancelation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancelation 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 Workers' Compensation Commission.
3. Notice of cancelation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancelation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancelation 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 Workers' Compensation Commission that it is insuring you as an employer, such notice shall be a cancelation of this policy effective when the other policy starts.

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 shall 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 Workers' Compensation Commission. You may, in writing, elect to waive this notification requirement.

We shall, 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: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, P.O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 242
(4-84)

WC 20 03 01

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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).

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 20 03 02 A (Ed. 9/08)

MASSACHUSETTS – ASSESSMENT CHARGE

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 Accidents (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.

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

WC 21 03 04 (Ed. 4-84)

MICHIGAN LAW ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

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

Michigan law requires that we attach this paragraph to your policy in the language specified by the statute. To help you understand the paragraph, the following definitions are added:

1. We are "the insurer issuing this policy"
2. You are "the insured employer"
3. "Michigan workmen's compensation act" means the Workers' Disability Compensation Act of 1969"
4. "Workmen's compensation" means workers compensation"
5. "The bureau of workmen's compensation" means the Bureau of Workers' Disability Compensation"

"Notwithstanding any language elsewhere contained in this contract or policy of insurance, the accident fund or the insurer issuing this policy hereby contracts and agrees with the insured employer:

Compensation

a. That it will pay to the persons that may become entitled thereto all workmen's compensation for which the insured employer may become liable under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Medical Services

b. That it will furnish or cause to be furnished to all employees of the employer all reasonable medical, surgical, and hospital services and medicines when they are needed, which the employer may be obligated to furnish or cause to be furnished to his employees under the provisions of the Michigan workmen's compensation act, and that it will pay to the persons entitled thereto for all such services and medicines when they are needed for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Rehabilitation Services

c. That it will furnish or cause to be furnished such rehabilitation services for which the insured employer may become liable to furnish or cause to be furnished under the provisions of the Michigan workmen's compensation act for all compensable injuries or compensable occupational diseases happening to his employees during the life of this contract or policy;

Funeral Expenses

d. That it will pay or cause to be paid the reasonable expense of the last sickness and burial of all employees whose deaths are caused by compensable injuries or compensable occupational diseases happening during the life of this contract or policy and arising out of and in the course of their employment with the employer, which the employer may be obligated to pay under the provisions of the Michigan workmen's compensation act;

Scope of Contract

e. That this insurance contract or policy shall for all purposes be held and deemed to cover all the businesses the said employer is engaged in at the time of the issuance of this contract or policy and all other businesses, if any, the employer may engage in during the life thereof, and all employees the employer may employ in any of his businesses during the period covered by this policy;

Obligations Assumed

f. That it hereby assumes all obligations imposed upon the employer by his acceptance of the Michigan workmen's compensation act, as far as the payment of compensation, death benefits, medical, surgical, hospital care or medicine and rehabilitation services is concerned;

Termination Notice

g. That it will file with the bureau of workmen's compensation at Lansing, Michigan, at least 20 days before the taking effect of any termination or cancelation of this contract or policy, a notice giving the date at which it is proposed to terminate or cancel this contract or policy; and that any termination of this policy shall not be effective as far as the employees of the insured employer are concerned until 20 days after notice of proposed termination or cancelation is received by the bureau of workmen's compensation;

Conflicting Provisions

h. That all the provisions of this contract, if any, which are not in harmony with this paragraph are to be construed as modified hereby, and all conditions and limitations in the policy, if any, conflicting herewith are hereby made null and void."

WC 21 06 01 (Ed. 4-84)

MICHIGAN DUAL OR JOINT EMPLOYMENT ENDORSEMENT

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

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

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

Issued to PAMLAB INC.

Endorsement No.

Countersigned by _____

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

Dual employment or joint employment occurs when an employee acts under the simultaneous or separate control of you and one or more other employers. If an employee is injured in the course of dual or joint employment:

A. The total amount of benefits payable to or on behalf of the employee, to the extent not apportioned to prior employers,

   1. will not exceed the amount that would be payable if the employee had been employed by only one employer with a wage equal to the combined wages from all of the joint or dual employers, and

   2. will be shared by us and the other employers or their insurance carriers.

B. We will be liable only for the percentage of benefits that equals the percentage payable by you of the total wages payable to the employee in course of the dual or joint employment on the date on which the bodily injury occurs.

TEXAS DEDUCTIBLE NOTICE OF ELECTION

Texas law permits an employer to obtain workers' compensation insurance with a deductible. The Insurance applies only to benefits payable under Texas workers' compensation law. When a deductible is elected, the policyholder is required to reimburse the insurance carrier for benefits payable under the law up to the deductible amount and a credit is applied to the policy. Premium credits 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 insurance 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. $ _____ annual aggregate
3. $ _____ /$ _____ per accident/annual aggregate

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 one for the following reason:_____

_____

The deductible plans have been explained to me.

_____ _____
Signature and Title Date

_____ _____
Employer Name (print or type) Address

CHUBB INDEMNITY INSURANCE COMPANY (13)7575-25-17 08/19/12
Insurance Company Policy No. Effective Date

Form 08 02 0251 (Rev. 1-97)

GEORGIA WORKERS' COMPENSATION DEDUCTIBLE DISCLOSURE NOTICE AND SELECTION FORM

Georgia law requires that we provide a notice outlining the available deductibles for medical and/or indemnity expenses payable under your WORKERS' COMPENSATION AND EMPLOYERS LIABILITY POLICY issued by a member company of the Chubb Group of Insurance Companies. Any deductible you select will apply separately to each compensable claim.

If you select a deductible, your workers' compensation premium will be reduced by the appropriate premium percentage. For multi-state workers' compensation policies, the reduction will apply to the portion of the premium attributable to your Georgia operations.

Your policy may or may not already include a deductible. If you do not wish to change your policy, you do not have to return this form. If your policy does not have a deductible and you want one, or if your policy has a deductible and you want to change it, please place an "x" next to the deductible you want and return the signed, completed form to Chubb or your agent. If you select a deductible, the deductible change will be effective on the beginning of your policy period if the form is received within 30 days of the policy period effective date. In all other cases, the deductible will be effective at the subsequent anniversary of your existing policy.

	Deductible Amount
_____	$ 100
_____	$ 200
_____	$ 300
_____	$ 400
_____	$ 500
_____	$ 1,000
_____	$ 1,500
_____	$ 2,000
_____	$ 2,500
_____	$ 5,000
_____	$ 10,000
_____	$ 20,000

Signed: _____ Date: _____

Authorized Representative
of Named Insured

Named Insured: PAMLAB INC.

Named Insured's Mailing Address P.O. BOX 8950
MANDEVILLE LA 70470

Binder/Policy Number: (13)7575-25-17

Name and Address of Agent: STONE INSURANCE, INC.
1502 W.CAUSEWAY APPROACH
MANDEVILLE LA 70471

NOTICE OF ELECTION TO ACCEPT OR REJECT AN INSURANCE DEDUCTIBLE FOR DELAWARE WORKERS' COMPENSATION DEATH AND MEDICAL BENEFITS

Delaware Law permits an employer to buy workers' compensation insurance with a deductible. The deductible is for death and medical benefits and applies to each accident.

The deductibles available are:

$500, $1000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $4,500 and $5,000.

You are not required to choose a deductible program. However, if you do so choose, it is to be understood that your insurance company will administer and pay all claims and that you will reimburse the insurance company for payments it makes within the amount of the deductible selected. Failure to reimburse the insurance company for such deductible amounts within 30 days can result in cancelation of coverage.

Please show whether or not you want the deductible by initialing the appropriate choice below.

_____ Yes, I want a deductible of $ _____ applied to death and medical benefits under the Delaware Workers' Compensation Law. I understand that the company shall pay the deductible amount and be reimbursed by the employer shown below.

_____ No, I do not want the deductible described in this Notice.

I understand that in accordance with 19 **Del. C.** §2372, I have the option of modifying the above deductible program choice at the time of renewal of my workers' compensation insurance policy with the insurance company named below.

_____ _____
(Signature) (Date of This Notice)

_____
(Title)

PAMLAB INC.
(Employer Name)

P.O. BOX 8950 MANDEVILLE LA 70470
(Employer Address)

CHUBB INDEMNITY INSURANCE COMPANY (13)7575-25-17
(Insurance Company) (Policy Number)

NOTICE OF ELECTION OF COVERAGE

STATE USE ONLY
Effective/Issue Date:
Control Number:
Postmark Date:
Received Date:

The applicant (s) herein elect to be included in the definition of employee, eligible for workers' compensation benefits pursuant to Chapter 440, Florida Statues as a non-construction industry (check one):

☐ **Sole Proprietor**

☐ **Partner**

Business Entity

PLEASE TYPE OR PRINT

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:	UI Number:	Telephone Number:	

Workers' Compensation Insurance Provider

Name of Insurer: CHUBB INDEMNITY INSURANCE COMPANY	
Address of Insurer: 2800 POST OAK BLVD SUITE 2400 HOUSTON, TX 77056-6118	
Policy Number: (13)7575-25-17	Effective Date of Policy: 08/19/12

Applicant (s)

	STATE USE ONLY
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:

SUBMIT THIS FORM TO:

DIVISION OF WORKERS' COMPENSATION
BUREAU OF COMPLIANCE
200 East Gaines Street
Tallahassee, FL 32399-4228

REVOCATION OF ELECTION OF COVERAGE

STATE USE ONLY
Effective/Issue Date:
Control Number:
Postmark Date:
Received Date:

By filing this Revocation, you elect to be exempt from the provisions of Chapter 440, Florida Statutes, and WAIVE ANY RIGHT YOU MAY HAVE to workers' compensatio n benefits in the State of Florida should you become injured on the job.

☐ **Sole Proprietor**
☐ **Partner**

Business Entity

PLEASE TYPE OR PRINT

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:	UI Number:	Telephone Number:	

Workers' Compensation Insurance Provider

Name of Insurer:	CHUBB INDEMNITY INSURANCE COMPANY
Address of Insurer:	2800 POST OAK BLVD SUITE 2400 HOUSTON, TX 77056-6118
Policy Number:	(13)7575-25-17
Effective Date of Policy:	08/19/12

Applicant(s)

	STATE USE ONLY
Name:_____ Social Security #: _____ Signature:_____ Date: _____	Effective/Issue Date:
Name:_____ Social Security #: _____ Signature:_____ Date: _____	Effective/Issue Date:
Name:_____ Social Security #: _____ Signature:_____ Date: _____	Effective/Issue Date:

SUBMIT THIS FORM TO:

DIVISION OF WORKERS' COMPENSATION
BUREAU OF COMPLIANCE
200 East Gaines Street
Tallahassee, FL 32399-4228

WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE POLICY

WC 04 03 01B (Ed. 1-12)

POLICY AMENDATORY ENDORSEMENT - CALIFORNIA

This endorsement changes the policy to which it is attached effective on the inception date of the policy unless a different date is indicated below.

(The following "attaching clause" need be completed only when this endorsement is issued subsequent to preparation of the policy.)

This endorsement, effective on 08/19/12 (DATE) at 12:01 A. M. standard time, forms a part of

Policy No. (13)7575-25-17 of the CHUBB INDEMNITY INSURANCE COMPANY (NAME OF INSURANCE COMPANY)

issued to PAMLAB INC.

Endorsement No.

_____
Authorized Representative

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 Subdivisoin (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 cancellation 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.

WC SCHEDULE RATING WORKSHEET
WEST VIRGINIA
Effective 7/1/2008 and subsequent

Insured Name: PAMLAB INC.

Mailing Address: P.O. BOX 8950
MANDEVILLE LA 70470

Policy Type	Policy Number	Policy Term	Underwriting Company
Work Comp	(13)7575-25-17	08/19/12 08/19/13	CHUBB INDEMNITY INSURANCE COMPANY

Category	Available Range of Modification	Credit	Debit	Reason/Basis
Premises	10% to 10%		0%	AVG RISK
Classification Peculiarities	10% to 10%		0%	AVG RISK
Medical Facilities	5% to 5%		0%	AVG RISK
Safety Devices	5% to 5%	5%		OSHA CERTIFIED
Employees – Training/Supervision	10% to 10%	10%		RANDOM DRUG TESTING
Management – Cooperation/Attitude	5% to 5%	5%		LC RECS
Management - Safety Organization	5% to 5%	5%		SAFETY PROGRAM
	Total	25	0	MAXIMUM = 25%