TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: **UB-6N259033-22-14-G**

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA 060 004

INSURED'S NAME: CHAMPLAIN COLLEGE INCORPORATED **13579-CA**

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 030220266 ENTITY CD 001 00				
CHAMPLAIN COLLEGE INCORPORATED				
NO BUSINESS LOCATION SACRAMENTO , CA 94203 NAICS: 611699				
COLLEGES OR SCHOOLS-PRIVATE-NOT AUTOMOBILE SCHOOLS-PROFESSORS, TEACHERS OR ACADEMIC PROFESSIONAL EMPLOYEES	8868	115554.00	0.79	913

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: **UB-6N259033-22-14-G**

CA MANUAL PREMIUM $ 913

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD. $	913
EXPERIENCE MODIFICATION:NONE MODIFIED PREMIUM	NONE
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	913
-4.60% PREMIUM DISCOUNT(0064)	-42
TERRORISM(9740)	23
TOTAL ESTIMATED PREMIUM	894
1.9277% WC ADMIN REVOLVING FUND ASSESSMENT	17
0.4856% STATE FRAUD SURCHARGE	4
0.1455% UNINSURED EMPLOYERS BENEFIT TRUST FUND ASST	1
1.7451% SUBSEQUENT INJURY BENEFIT TRUST FUND ASST	16
0.9177% OCCUPATIONAL SAFETY & HEALTH FUND ASSESSMENT	8
0.7102% LABOR ENFORCEMENT & COMPLIANCE FUND ASSESSMENT	6
TOTAL PREMIUM	946
DEPOSIT AMOUNT DUE	946

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 03 01 (B)

POLICY NUMBER: UB-6N259033-22-14-G

POLICY AMENDATORY ENDORSEMENT – CALIFORNIA

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

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

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

   This workers compensation insurance applies to bodily injury by accident or disease, including death resulting therefrom. Bodily injury by accident must occur during the policy period. Bodily injury by disease must be caused or aggravated by the conditions of your employment. Your employee's exposure to those conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. **Rate Changes.** The premium and rates with respect to the insurance provided by this policy by reason of the designation of California in Item 3 of the Information Page are subject to change if ordered by the Insurance Commissioner of the State of California pursuant to Section 11737 of the California Insurance Code.
6. **Long Term Policy.** If this policy is written for a period longer than one year, all the provisions of this policy shall apply separately to each consecutive twelve-month period or, if the first or last consecutive period is less than twelve months, to such period of less than twelve months, in the same manner as if a separate policy had been written for each consecutive period.
7. **Statutory Provision.** Your employee has a first lien upon any amount which becomes owing to you by us on account of this policy, and in the case of your legal incapacity or inability to receive the money and pay it to the claimant, we will pay it directly to the claimant.
8. Part Five, "Premium", E, "Final Premium", is amended to read as follows:

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

the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

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

a. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

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

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

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured	Insurance Company	

Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 99 03 99 (00)

POLICY NUMBER: **UB-6N259033-22-14-G**

CALIFORNIA WORKERS' COMPENSATION NOTICE OF NON-RENEWAL

Section 11664 of the California Insurance Code which becomes operative November 30, 1994 requires us in most instances to provide you with a notice of non-renewal. Except as specified in paragraphs 1 through 6 below, if we elect to non-renew your policy, we are required to deliver or mail to you a written notice stating the reason or reasons for the non-renewal 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 non-renewal 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 at least 30 days, but not more than 120 days, prior to the end of the policy period to renew the policy at a changed premium rate.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY INSURANCE POLICY
ENDORSEMENT WC 99 03 F3 (00)

POLICY NUMBER: **UB-6N259033-22-14-G**

CALIFORNIA LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because California 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	$1,000,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, each accident
Bodily Injury by Disease	$1,000,000	or the amount shown in Item 3.B. of the Information Page, whichever is greater, policy limit
Bodily Injury by Disease	$1,000,000	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 California operations only.

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY ENDORSEMENT WC 04 03 60 (B)

POLICY NUMBER: UB-6N259033-22-14-G

EMPLOYERS' LIABILITY COVERAGE AMENDATORY ENDORSEMENT CALIFORNIA

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

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

A. How This Insurance Applies

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

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

2. The employment must be necessary or incidental to your work in California.

3. Bodily injury by accident must occur during the policy period.

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

5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

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

1. Exclusion 1 is amended to read as follows:

1. liability assumed under a contract.

2. Exclusion 2 is deleted.

3. Exclusion 7 is amended to read as follows:

7. damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, termination of employment, or any personnel practices, policies, acts or omissions.

4. The following exclusions are added:

1. bodily injury to any member of the flying crew of any aircraft.

2. bodily injury to an employee when you are deprived of statutory or common law defenses or are subject to penalty because of your failure to secure your obligations under the workers' compensation law(s) applicable to you or otherwise fail to comply with that law.

3. liability arising from California Labor Code Section 2810.3 which relates to labor contracting.

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

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

Endorsement Effective | Policy No. | Endorsement No.

Insured | Premium

Insurance Company | Countersigned by _____

DATE OF ISSUE: 02-14-22 ST ASSIGN:

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 21 (00)

POLICY NUMBER: UB-6N259033-22-14-G

OPTIONAL PREMIUM INCREASE ENDORSEMENT – CALIFORNIA

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

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

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

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

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

Endorsement Effective	Policy No.	Endorsement No.
Insured	Insurance Company	

Countersigned By _____

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-6N259033-22-14-G

CALIFORNIA SHORT-RATE CANCELATION ENDORSEMENT

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

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

Short Rate Cancelation Table

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
1	5%	18.2482	46	23%	1.8250	91	35%	1.4038
2	6	10.9489	47	23	1.7861	92	36	1.4283
3	7	8.5158	48	24	1.8250	93	36	1.4129
4	7	6.3869	49	24	1.7877	94	36	1.3979
5	8	5.8394	50	24	1.7520	95	37	1.4216
6	8	4.8662	51	24	1.7176	96	37	1.4068
7	9	4.6924	52	25	1.7548	97	37	1.3923
8	9	4.1058	53	25	1.7216	98	37	1.3781
9	10	4.0552	54	25	1.6899	99	38	1.4010
10	10	3.6496	55	26	1.7255	100	38	1.3870
11	11	3.6496	56	26	1.6947	101	38	1.3733
12	11	3.3455	57	26	1.6650	102	38	1.3598
13	12	3.3689	58	26	1.6362	103	39	1.3820
14	12	3.1283	59	27	1.6704	104	39	1.3688
15	13	3.1630	60	27	1.6425	105	39	1.3557
16	13	2.9653	61	27	1.6156	106	40	1.3774
17	14	3.0056	62	27	1.5895	107	40	1.3645
18	14	2.8386	63	28	1.6222	108	40	1.3519
19	15	2.8818	64	28	1.5969	109	40	1.3395
20	15	2.7377	65	28	1.5723	110	41	1.3605
21	16	2.7812	66	29	1.6038	111	41	1.3482
22	16	2.6547	67	29	1.5799	112	41	1.3362
23	17	2.6980	68	29	1.5566	113	41	1.3243
24	17	2.5856	69	29	1.5341	114	42	1.3447
25	17	2.4821	70	30	1.5643	115	42	1.3330
26	18	2.5270	71	30	1.5423	116	42	1.3215
27	18	2.4334	72	30	1.5208	117	43	1.3414
28	18	2.3465	73	30	1.5000	118	43	1.3301
29	18	2.2656	74	31	1.5291	119	43	1.3189
30	19	2.3117	75	31	1.5087	120	43	1.3079
31	19	2.2371	76	31	1.4888	121	44	1.3273
32	19	2.1672	77	32	1.5169	122	44	1.3164
33	20	2.2121	78	32	1.4974	123	44	1.3057
34	20	2.1471	79	32	1.4785	124	44	1.2951
35	20	2.0857	80	32	1.4600	125	45	1.3140
36	20	2.0278	81	33	1.4870	126	45	1.3036
37	21	2.0716	82	33	1.4689	127	45	1.2933
38	21	2.0171	83	33	1.4512	128	46	1.3117
39	21	1.9654	84	34	1.4774	129	46	1.3016
40	21	1.9162	85	34	1.4600	130	46	1.2916
41	22	1.9585	86	34	1.4430	131	46	1.2817
42	22	1.9119	87	34	1.4264	132	47	1.2996
43	22	1.8674	88	35	1.4517	133	47	1.2899
44	23	1.9079	89	35	1.4354	134	47	1.2802
45	23	1.8655	90	35	1.4194	135	47	1.2708

DATE OF ISSUE: 02-14-22 ST ASSIGN:

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-6N259033-22-14-G

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
136	48%	1.2882	181	60%	1.2099	226	70%	1.1305
137	48	1.2788	182	60	1.2033	227	70	1.1255
138	48	1.2696	183	61	1.2167	228	70	1.1206
139	49	1.2867	184	61	1.2101	229	71	1.1317
140	49	1.2775	185	61	1.2035	230	71	1.1267
141	49	1.2684	186	61	1.1970	231	71	1.1219
142	49	1.2595	187	61	1.1906	232	71	1.1170
143	50	1.2762	188	62	1.2037	233	72	1.1279
144	50	1.2674	189	62	1.1974	234	72	1.1231
145	50	1.2586	190	62	1.1910	235	72	1.1183
146	50	1.2500	191	62	1.1848	236	72	1.1136
147	51	1.2663	192	63	1.1977	237	72	1.1089
148	51	1.2578	193	63	1.1914	238	73	1.1195
149	51	1.2493	194	63	1.1853	239	73	1.1149
150	52	1.2653	195	63	1.1792	240	73	1.1102
151	52	1.2569	196	63	1.1732	241	73	1.1056
152	52	1.2487	197	64	1.1858	242	74	1.1161
153	52	1.2405	198	64	1.1798	243	74	1.1115
154	53	1.2562	199	64	1.1739	244	74	1.1070
155	53	1.2481	200	64	1.1680	245	74	1.1025
156	53	1.2401	201	65	1.1804	246	74	1.0980
157	54	1.2554	202	65	1.1745	247	75	1.1083
158	54	1.2475	203	65	1.1687	248	75	1.1038
159	54	1.2396	204	65	1.1630	249	75	1.0994
160	54	1.2319	205	65	1.1573	250	75	1.0950
161	55	1.2469	206	66	1.1694	251	76	1.1052
162	55	1.2392	207	66	1.1638	252	76	1.1008
163	55	1.2316	208	66	1.1582	253	76	1.0964
164	55	1.2241	209	66	1.1526	254	76	1.0921
165	56	1.2388	210	67	1.1645	255	76	1.0878
166	56	1.2313	211	67	1.1590	256	77	1.0979
167	56	1.2240	212	67	1.1535	257	77	1.0936
168	57	1.2384	213	67	1.1481	258	77	1.0893
169	57	1.2311	214	67	1.1428	259	77	1.0851
170	57	1.2238	215	68	1.1544	260	77	1.0810
171	57	1.2167	216	68	1.1491	261	78	1.0908
172	58	1.2308	217	68	1.1438	262	78	1.0866
173	58	1.2237	218	68	1.1385	263	78	1.0825
174	58	1.2167	219	69	1.1500	264	78	1.0784
175	58	1.2097	220	69	1.1448	265	79	1.0881
176	59	1.2236	221	69	1.1396	266	79	1.0840
177	59	1.2167	222	69	1.1345	267	79	1.0800
178	59	1.2098	223	69	1.1294	268	79	1.0759
179	60	1.2235	224	70	1.1406	269	79	1.0719
180	60	1.2167	225	70	1.1356	270	80	1.0815

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 04 22 (00)

POLICY NUMBER: UB-6N259033-22-14-G

Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect	Days in Policy Period	Short Rate Percentages	Factors to Apply to Earned Premium for Period Policy in Effect
271	80%	1.0775	316	90%	1.0396	361	100%	1.0111
272	80	1.0735	317	90	1.0363	362	100	1.0083
273	80	1.0696	318	90	1.0330	363	100	1.0055
274	81	1.0790	319	90	1.0298	364	100	1.0027
275	81	1.0751	320	91	1.0380	365	100	1.0000
276	81	1.0712	321	91	1.0347			
277	81	1.0673	322	91	1.0315			
278	81	1.0635	323	91	1.0283			
279	82	1.0728	324	92	1.0364			
280	82	1.0689	325	92	1.0332			
281	82	1.0651	326	92	1.0301			
282	82	1.0614	327	92	1.0269			
283	83	1.0705	328	92	1.0238			
284	83	1.0667	329	93	1.0318			
285	83	1.0630	330	93	1.0286			
286	83	1.0593	331	93	1.0255			
287	83	1.0556	332	93	1.0224			
288	84	1.0646	333	94	1.0303			
289	84	1.0609	334	94	1.0272			
290	84	1.0572	335	94	1.0242			
291	84	1.0536	336	94	1.0211			
292	85	1.0625	337	94	1.0181			
293	85	1.0589	338	95	1.0259			
294	85	1.0553	339	95	1.0229			
295	85	1.0517	340	95	1.0198			
296	85	1.0481	341	95	1.0169			
297	86	1.0569	342	95	1.0139			
298	86	1.0534	343	96	1.0216			
299	86	1.0498	344	96	1.0186			
300	86	1.0463	345	96	1.0156			
301	86	1.0429	346	96	1.0127			
302	87	1.0515	347	97	1.0203			
303	87	1.0480	348	97	1.0174			
304	87	1.0446	349	97	1.0145			
305	87	1.0411	350	97	1.0116			
306	88	1.0497	351	97	1.0087			
307	88	1.0462	352	98	1.0162			
308	88	1.0429	353	98	1.0133			
309	88	1.0395	354	98	1.0105			
310	88	1.0361	355	98	1.0076			
311	89	1.0445	356	99	1.0150			
312	89	1.0412	357	99	1.0122			
313	89	1.0379	358	99	1.0094			
314	89	1.0346	359	99	1.0065			
315	90	1.0429	360	99	1.0038			

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by _____

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 01 (A)

POLICY NUMBER: **UB-6N259033-22-14-G**

CALIFORNIA CANCELATION ENDORSEMENT

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.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 04 (00)

POLICY NUMBER: UB-6N259033-22-14-G

COVID-19 REPORTING REQUIREMENT ENDORSEMENT – CALIFORNIA

In addition to the requirements under Part 4, "Your Duties if Injury Occurs" of your policy, if you have five or more employees and an employee that is not described in California Labor Code section 3212.87 tests positive for COVID-19, you are required to report the following information as provided below.

Reporting COVID-19 Positive Tests from July 6, 2020 to September 17, 2020

Pursuant to California Labor Code Section 3212.88(k)(2), if you are aware of an employee testing positive for COVID-19 on or after July 6, 2020 and prior to September 17, 2020, you must report to your claims administrator in writing via electronic mail or facsimile within 30 business days of September 17, 2020, all of the following:

(1) An employee has tested positive. For purposes of this reporting, do not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to California Labor Code Section 5401.

(2) The date that the employee tests positive, which is the date the specimen was collected for testing.

(3) The specific address or addresses of the employee's specific place of employment during the 14-day period preceding the date of the employee's positive test.

(4) The highest number of employees who reported to work at each of the employee's specific places of employment on any given work day between July 6, 2020 and September 17, 2020

Reporting COVID-19 Positive Tests from September 17, 2020 to January 1, 2023

Pursuant to California Labor Code Section 3212.88(i), when you know, or reasonably should know, that an employee has tested positive for COVID-19 between September 17, 2020 and January 1, 2023, you must report to your claims administrator in writing via electronic mail or facsimile within 3 business days all of the following:

(1) An employee has tested positive. For purposes of this reporting, do not provide any personally identifiable information regarding the employee who tested positive for COVID-19 unless the employee asserts the infection is work related or has filed a claim form pursuant to California Labor Code Section 5401.

(2) The date that the employee tests positive, which is the date the specimen was collected for testing.

(3) The specific address or addresses of the employee's specific place of employment during the 14-day period preceding the date of the employee's positive test.

(4) The highest number of employees who reported to work at the employee's specific place of employment in the 45-day period preceding the last day the employee worked at each specific place of employment.

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 04 06 04 (00)

POLICY NUMBER: UB-6N259033-22-14-G

Labor Code Section 3212.88(j) states that the intentional submission of false or misleading information or the failure to report the above information as required may subject you to a civil penalty in the amount of up to $10,000 to be assessed by the Labor Commissioner.

For the purposes of these reporting requirements, California Labor Code Section 3212.88(m) provides the following:

(1) "COVID-19" means the 2019 novel coronavirus disease.

(2) "Test" or "testing" means a PCR (Polymerase Chain Reaction) test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA. "Test" or "testing" does not include serologic testing, also known as antibody testing. "Test" or "testing" may include any other viral culture test approved for use or approved for emergency use by the United States Food and Drug Administration to detect the presence of viral RNA which has the same or higher sensitivity and specificity as the PCR Test.

(3) "A specific place of employment" means the building, store, facility, or agricultural field where an employee performs work at the employer's direction. "A specific place of employment" does not include the employee's home or residence, unless the employee provides home health care services to another individual at the employee's home or residence.

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

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

Endorsement Effective Policy No. Endorsement No.
Insured Premium

Insurance Company Countersigned by _____

TRAVELERS

Travelers Medical Provider Network (MPN) Plan – CALIFORNIA
Necessary Action for MPN Participation

Dear Policyholder:

As your workers compensation insurer, Travelers is pleased to include your Company in our California Medical Provider Network (MPN) plan. Travelers has an extensive MPN with physicians who understand workers compensation and are experienced in providing expert care for injured workers. Our program ensures that every covered employee that suffers a work-related injury or illness has access to prompt medical care and an improved likelihood of a safe return to work as soon as medically appropriate. MPN utilization can reduce overall workers compensation claim payouts by providing greater control over medical fees and obtaining more favorable medical treatment outcomes. Your role is crucial to the success of the MPN program. Together, we can better manage your Workers Compensation claims within the MPN.

The MPN is a standard product in all Travelers workers compensation policies, and all policyholders are expected to participate. This information is being provided to you to help you understand the requirements for proper MPN participation.

The State Division of Workers' Compensation (DWC) regulates how an employee is notified of an employer's MPN participation. Section § 9767.12 of Title 8, California Code of Regulations specifies what notices are to be provided to employees, as well as when and how they are to be provided. Information about the Travelers MPN and notice requirements is available to policyholders on **www.travelers.com**. Please type this web address into your browser to access the information:

www.travelers.com/CAMPN

A "**F**requently **A**sked **Q**uestions" page is also available through the above web address. Look for the link called **FAQ – MPN.** If you have additional, general questions regarding the MPN and do not have a contact in the Claim Department, you can contact the **Travelers MPN Team** by calling **(800) 287-9682** or sending an email to **CAMPN@travelers.com**. Please listen for the prompts for *Employers or Employer Representatives*.

In addition to reviewing the information on our web page, we also recommend that you:

- Make sure your management staff has instructions on how to access the MPN Medical Provider directory via **www.travelers.com/CAMPN.**
- Select an occupational medicine clinic, urgent care clinic, or, an acute care hospital from the MPN to serve as your designated initial injury treatment facility for each plant/location. Contact this facility and inform them that you are participating in the Travelers Medical Provider Network Plan. Update the State Posting Notices to include the name, address, and phone number of the facility.
- Review your procedures for handling work-related injuries, your modified duty policy, and your safety committee operation with your management staff.

We believe the MPN program will provide better overall workers compensation outcomes for you as an employer.

Sincerely,

Travelers

STATE OF CALIFORNIA
IMPORTANT LOSS CONTROL INFORMATION

California Labor Code § 6354.5 (b)(3) requires workers' compensation insurance carriers to provide their California policyholders with occupational safety and health loss control consultation services at no additional charge. See the enclosed Safety Services notice for a list of services available and for the phone number and address of the Travelers Risk Control office nearest you.

Notice To Policy Recipient:

If you are not the person directly responsible for the loss control activities of your company in California, please direct these safety services notices to the person directly responsible for loss control activities.

IMPORTANT NOTICE TO CALIFORNIA EMPLOYERS

NO COVERAGE IS PROVIDED BY THIS NOTICE. THIS NOTICE DOES NOT AMEND ANY PROVISION OF YOUR POLICY. YOU SHOULD REVIEW YOUR ENTIRE POLICY CAREFULLY FOR COMPLETE INFORMATION ON THE COVERAGES PROVIDED AND TO DETERMINE YOUR RIGHTS AND DUTIES UNDER YOUR POLICY. PLEASE CONTACT YOUR AGENT OR BROKER IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR ITS CONTENTS. IF THERE IS ANY CONFLICT BETWEEN YOUR POLICY AND THIS NOTICE, THE PROVISIONS OF YOUR POLICY PREVAIL.

California Labor Code Section 3550 requires you to post and keep posted in each of your California workplaces, in a conspicuous location frequented by employees, a notice that states the name of your current workers compensation insurance carrier and who is responsible for claims adjustment. The notice must be posted in English and Spanish if you have Spanish-speaking employees. Failure to keep the notice posted as required constitutes a misdemeanor.

For your convenience, we have enclosed copies of notice DWC 7, Notice to Employees – Injuries Caused by Work, for each of your California locations.

POLICYHOLDER NOTICE

SHORT RATE CANCELATION
CALIFORNIA INSURANCE CODE SECTION 481

CA Insurance Code Section 481 requires that where an insurance policy includes a provision to refund premium on anything other than a pro rata basis, including the assessment of cancellation fees, the insurer must disclose that fact to the policyholder in writing prior to, or concurrent with, the proposal or quote prior to each renewal. The disclosure must include the actual or maximum fees or penalties to be applied. The WCIRB also created a Short Rate Cancelation Endorsement which complements the disclosure requirement. This requirement applies to insurance policies issued or renewed on or after January 1, 2012.

In order to respond to this insurance code requirement we have created this Policyholder Notice to disclose our use of short rate calculations as described in the California Short Rate Cancelation Endorsement included in the policy.

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

CALIFORNIA WORKERS' COMPENSATION INSURANCE NOTICE OF NONRENEWAL

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

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

1. Your policy was transferred or renewed without a change in its terms or conditions or the rate on which the premium is based to another insurer or other insurers who are members of the same insurance group as us.
2. The policy was extended for 90 days or less and the required notice was given prior to the extension.

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

4. The policy is for a period of no more than 60 days and you were notified at the time of issuance that it may not be renewed.

5. You requested a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

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

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

(1) General questions regarding your policy should be directed to:

TRAVELERS
P.O. Box 6512
21688 Gateway Center Drive
Diamond Bar, CA 91765
Telephone: 1-909-612-3609
Fax: 1-909-612-3629
Website: www.travelers.com

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

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

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

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

(1) The WCIRB is a licensed rating organization and the California Insurance Commissioner's designated statistical agent. As such, the WCIRB is responsible for administering the *California Workers' Compensation Uniform Statistical Reporting Plan–1995* (USRP) and the *California Workers' Compensation Experience Rating Plan–1995* (ERP). WCIRB contact information is: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service; 888.229.2472 (phone); 415.778.7272 (fax); and customerservice@wcirb.com (email). The regulations contained in the USRP and ERP are available for public viewing through the WCIRB's website at wcirb.com.

(2) Policyholder Information. Pursuant to California Insurance Code (CIC) Section 11752.6, upon written request, you are entitled to information relating to loss experience, claims, classification assignments, and policy contracts as well as rating plans, rating systems, manual rules, or other information impacting your premium that is maintained in the records of the WCIRB. Complaints and Requests for Action requesting policyholder information should be forwarded to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Custodian of Records. The Custodian of Records can be reached at 415.777.0777 (phone) and 415.778.7272 (fax).

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

II. Dispute Process

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

A. Our Dispute Resolution Process.

If you are aggrieved by our decision adopting a change in a classification assignment that results in increased premium, or by the application of our rating system to your workers' compensation insurance, you may dispute these matters with us. If you are dissatisfied with the outcome of the initial dispute with us, you may send us a written Complaint and Request for Action as outlined below.]

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:

TRAVELERS
1109 White Rock Road
Rancho Cordova, CA 95670-6001

Phone: 1-800-328-2189

Website: www.Travelers.com

TRAVELERS
P.O. Box 6512
21688 Gateway Center Drive
Diamond Bar, CA 91765
Phone: 1-909-612-3609
Fax: 1-909-612-3629
Website: www.Travelers.com

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 7 of the ERP).

You may commence the review process by sending the WCIRB a written Inquiry. Written Inquiries should be sent to: WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Customer Service. Customer Service can be reached at 888.229.2472 (phone), 415.778.7272 (fax) and customerservice@wcirb.com (email).

If you are dissatisfied with the WCIRB's decision upon an Inquiry, or if the WCIRB fails to respond within 90 days after receipt of the Inquiry, you may pursue the subject of the Inquiry by sending the WCIRB a written Complaint and Request for Action. After you send your Complaint and Request for Action, the WCIRB has 30 days to send you written notice indicating whether 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, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Complaints and Reconsideration. The WCIRB's contact information is 888.229.2472 (phone), 415.371.5204 (fax) and customerservice@wcirb.com (email).

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

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

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

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

A. Policyholder Ombudsman. Pursuant to California Insurance Code Section 11752.6, a policyholder ombudsman is available at the WCIRB to assist you in obtaining and evaluating the rating, policy, and claims information referenced in I.A. and I.B., above. The ombudsman may advise you on any dispute with us, the WCIRB, or on an appeal to the Insurance Commissioner pursuant to Section 11737 of the Insurance Code. The address of the policyholder ombudsman is WCIRB, 1221 Broadway, Suite 900, Oakland, CA 94612, Attn: Policyholder Ombudsman. The policyholder ombudsman can be reached at 415.778.7159 (phone), 415.371.5288 (fax) and ombudsman@wcirb.com (email).

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

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

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.

TRAVELERS

Your Workers' Compensation Benefits

CALIFORNIA

This form should be given to all newly hired employees in the State of California. Its content applies to industrial injuries on or after January 1, 2013.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job, or are a victim of a workplace crime. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures to a harmful condition (such as hurting your wrist from doing the same motion over and over).

Workers' compensation benefits include:

Medical Care: Doctor visits, hospital services, physical therapy, lab tests, x-rays, and medicines that are reasonably necessary to treat your injury. You should never see a bill. Physical therapy, occupational therapy and chiropractic visits may be limited to 24 each.

Temporary Disability Benefits: Payments if you lose wages while recovering. For most injuries, temporary disability benefits are limited to 104 weeks within 5 years from your date of injury. Filing a timely Employment Development Department claim may result in additional state disability benefits when TTD benefits are terminated, delayed or denied.

Permanent Disability Benefits: Payments if your injury causes a permanent disability. Once your injury stabilizes, your treating physician may find permanent disability, depending upon your level of recovery. The amount of permanent disability found by your doctor will be rated by your claims administrator according to your age and occupation in order to determine the percentage and corresponding dollar amount of permanent disability due. These amounts are set by state law. You have the right to obtain a state disability rating or appeal a rating.

Supplemental Job Displacement Vouchers: If your injury causes you to miss time from work and results in permanent disability, you may receive a supplemental job displacement voucher if your employer has not offered modified, alternative or regular employment within 60 days of receipt of the doctor's medical report indicating you have made a maximum medical recovery. The voucher is for reimbursement of education-related costs and is capped at $6,000.00, If you receive a voucher as a result of your injury, you have two years from the date you are furnished the voucher or five years from your date of injury (whichever occurs later), to request reimbursement for qualifying expenditures.

Death Benefits: Paid to dependents of a worker who dies from a work-related injury or illness. Burial expenses are also provided, with the maximum amount allowed dependent upon the date of injury.

Return to Work Program: If you experience a permanent earnings loss as a result of your injury and your permanent disability benefits are determined to be disproportionately low, you may qualify for additional monies from the Department of Industrial Relation's Return to Work Fund. Contact the Department of Industrial Relations at: www.dir.ca.gov/ to learn more about this additional benefit.

Temporary disability, permanent disability, and death benefits are all payable at a rate based on 2/3 of your average weekly wage, and subject to state minimum and maximum amounts in effect on your date of injury. These benefits are paid every two weeks while you are eligible.

Voluntary, off duty, recreational, social or athletic activities may not be covered under workers' compensation.

If you get hurt:

Get Medical Care. If you need first aid, contact your employer. If you need emergency care, call for help immediately.

Report Your Injury. Report the injury immediately to your supervisor. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you a claim form within one working day after learning about your injury, and must also authorize treatment within one working day after you have returned a signed and completed copy of the form. The statute of limitations for filing a workers' compensation claim is one year from the date of injury or, if resulting from repeated exposures, one year from when you realized or should have realized that your job caused the injury.

See Your Treating Physician. Your primary treating physician is the doctor with overall responsibility for treating your injury or illness. He or she is charged with maintaining the continuity of your care, as well as initiating referrals to specialists. If your employer has an approved Medical Provider Network (MPN), they may be able to limit your choices of treating physicians retain medical control, and require you to treat with an MPN physician from the onset. (An MPN is a selected network of healthcare providers who provide treatment to workers injured on the job. See your employer for more information on your MPN.) Otherwise, your employer has the right to select the physician who will treat you for the first 30 days. If your employer does not have an approved MPN and you wish to change doctors in the first 30 days after reporting your claim, your claims administrator must select a new physician within five days of your request.

If you have provided your employer with the name of your personal physician before your injury and have group health insurance at the time of injury, you may see your personal physician for treatment even if your employer has an approved MPN. Your personal physician must be a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician- gynecologist, family practitioner, or multi-specialty medical group of doctors of medicine or osteopathy, and must have treated you and maintained your medical history and records before your work injury and must also agree to treat you for a work-related injury or illness. If your employer does not have an approved MPN and you gave your employer the name of your personal chiropractor or acupuncturist in writing before you were injured, you may switch to the chiropractor or acupuncturist upon request. If you still need medical care after 30 days, you may be able to switch to a doctor of your own choice.

For your convenience, optional forms to predesignate your personal physician or multi-specialty medical group of doctors of medicine or osteopathy are attached to this document. Also attached, are forms to predesignate your personal acupuncturist or chiropractor if your employer does not have a medical provider network in place. By law, chiropractors are not allowed to be the treating physician after 24 visits.

Discrimination: It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If your employer has been found to discriminate, you may be entitled to job reinstatement with back pay, increased compensation, and costs and expenses. You may also have additional rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-3362. You can get free information from a state Division of Workers' Compensation Information & Assistance Officer. Hear recorded information and a list of local offices by calling toll-free **(800) 736-7401** or learn more online at: **http://www.dir.ca.gov**.

If medical care is not being provided by your employer you have several options. First, contact your claims administrator to find out the status of your claim. If you have given your employer a completed and signed claim form but your claim has been delayed for investigation, your employer is still required to authorize treatment, up to $10,000.00, during the delay. If the claim has not been accepted yet and your medical costs have exceeded the statutory $10,000.00 cap, you can go to your group health plan for care, find a doctor, clinic or hospital that will bill the claims administrator directly, or use public health services.

You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your claims administrator first to see if you can resolve it.

Your Workers' Compensation Insurance Company is **Travelers Property Casualty Company of America**.

You can also look up your insurance carrier at the WCIRB online lookup: https://www.caworkcompcoverage.com/

You can obtain free information from an Information and Assistance Officer of the state Division of Workers' Compensation, or you can hear recorded information and a list of local offices by calling (800) 736-7401. A list of Information and Assistance offices can be found at the end of this pamphlet to help you locate the I&A office nearest you. You may also go to the DWC web site at: **http://www.dir.ca.gov** for further information.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their web site at: **http://www.californiaspecialist.org**. You may get a list of attorneys from your local information and assistance officer or look in your yellow pages.

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.) or doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury, you have health care coverage for injuries or illnesses that are not work related;
- 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, 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 nonoccupational 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 code) _____

(Telephone number) _____

Employee Name (please print): _____

Employee's Address: _____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____ **Date:** _____

Physician: I agree to this Predesignation.

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 Effective date July 1, 2014)

Predesignation of Personal Physician; Reporting Duties of the Primary Treating Physician Regulations 8 C.C.R. section 9780, et seq. (Approved 02/12/2014)

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004, or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(Telephone number)

Employee Name (please print): _____

Employee's Address:

_____

Employee's Signature _____ **Date:** _____

Title 8, California Code of Regulations, section 9783.1
(Optional DWC Form 9783.1 Effective date July 1, 2014)

Predesignation of Personal Physician; Reporting Duties of the Primary Treating Physician
Regulations 8 C.C.R. section 9780, et seq. (Approved 02/12/2014)

Contact the information & assistance unit

- By phone at 1-800-736-7401: For recorded information that helps injured workers, employers and others understand
- California's workers' compensation system, and their rights and responsibilities under the law.
- By attending a workshop for injured workers
- By calling or going in person to a local Information & Assistance Unit office:

Anaheim 1065 N. PacifiCenter Drive Anaheim, CA 92806 (714) 414-1801	**Oxnard** 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93030 (805) 485-3528	**San Francisco** 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	**Pomona** 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	**San Jose** 100 Paseo de San Antonio Room 241 San Jose, CA 95113-1402 (408) 277-1292
Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	**Redding** 2115 Civic Center Drive, Room 15 Redding, CA 96001-2796 (530) 225-2047	**San Luis Obispo** 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
Fresno 2550 Mariposa Mall, Room 2035 Fresno, CA 93721-2219 (559) 445-5355	**Riverside** 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	**Santa Ana** 605 W Santa Ana Blvd Bldg 28, Room 451 Santa Ana, CA 92701 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	**Sacramento** 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	**Santa Barbara** *Satellite office 130 East Ortega Street Santa Barbara, CA 93101-1631 (805) 884 1032
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	**Salinas** 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	**Santa Rosa** 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Marina del Rey 4720 Lincoln Blvd, 2nd floor Marina del Rey, CA 90292-6902 (310) 482-3820	**San Bernardino** 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	**Stockton** 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	**San Diego** 7575 Metropolitan Drive, Suite 202 San Diego, CA 92102-4424 (619) 767-2082	**Van Nuys** 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

TRAVELERS

Sus beneficios de compensación laboral

CALIFORNIA

Este formulario debe entregarse a todos los empleados recién contratados en el estado de California. Su contenido se aplica a los accidentes de trabajo ocurridos a partir del 1 de enero de 2013.

Cualquier persona que haga o propicie que se haga cualquier declaración sustancial a sabiendas falsa o fraudulenta con el propósito de obtener o denegar beneficios o pagos de compensación laboral es culpable de un delito.

Usted puede tener derecho a beneficios de compensación laboral si resulta lesionado o se enferma a causa de su trabajo, o si es víctima de un delito en el lugar de trabajo. La compensación laboral cubre la mayoría de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un acontecimiento (como lastimarse la espalda en una caída) o por exposiciones repetidas a una circunstancia perjudicial (como lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Los beneficios de compensación laboral incluyen:

Atención médica: consultas médicas, servicios hospitalarios, fisioterapia, análisis de laboratorio, radiografías y medicamentos que sean razonablemente necesarios para tratar su lesión. No debe recibir nunca una factura. Es posible que las visitas para fisioterapia, terapia ocupacional y al quiropráctico tengan un límite de 24 visitas para cada tipo.

Beneficios por incapacidad temporal: Pagos si usted deja de recibir su salario mientras se recupera. Para la mayoría de las lesiones ocurridas después del 18 de abril de 2004, los beneficios por incapacidad temporal se limitan a 104 semanas dentro del lapso de 5 años a partir de la fecha de la lesión. Presentar de forma oportuna una reclamación en el Departamento de Desarrollo Laboral (*Employment Development Department*) puede conducir a la obtención de beneficios estatales adicionales por incapacidad cuando se terminan los beneficios por incapacidad total temporal (TTD, por sus siglas en inglés), o cuando estos se demoran o los deniegan.

Beneficios por incapacidad permanente: Pagos si su lesión causa una incapacidad permanente. Una vez que su lesión se estabilice, es posible que el médico que lo trata determine que usted tiene una incapacidad permanente, dependiendo de su grado de recuperación. La cantidad de incapacidad permanente que su médico determine será clasificada por su administrador de reclamaciones según su edad y ocupación con el fin de determinar el porcentaje y la cantidad correspondiente en dólares que se le debe a usted a causa de la incapacidad permanente. La ley estatal establece dichas cantidades. Usted tiene derecho a obtener una clasificación estatal de incapacidad o a apelar la clasificación.

Vales suplementarios por destitución laboral: Si su lesión conlleva a que usted falte a su trabajo y le causa una incapacidad permanente, usted puede recibir un vale suplementario por destitución laboral si su empleador no le ofrece un empleo modificado, alternativo o regular dentro de 60 días de haber recibido el informe médico que indique que usted logró una recuperación médica máxima. El vale es para reembolsar los costos educativos y tiene un límite de $6,000.00. Si usted recibe un vale como consecuencia de su lesión, tiene dos años desde la fecha en que le proporcionen el vale o cinco años desde la fecha de su lesión (lo que ocurra último), para solicitar el reembolso de los gastos que califiquen.

Beneficios por muerte: Se pagan a los dependientes de un trabajador que muere a causa de una lesión o enfermedad laboral. También se cubren los gastos del entierro; la cantidad máxima permitida depende de la fecha de la lesión.

Los beneficios por incapacidad temporal, incapacidad permanente y muerte se pagan a una tasa basada en 2/3 de su salario semanal promedio, y están sujetos a las cantidades mínimas y máximas vigentes en el estado en la fecha de su lesión. Estos beneficios se pagan cada dos semanas mientras usted sea elegible.

Programa para reintegrarse al trabajo: Si usted sufre la pérdida permanente de sus ingresos como resultado de su lesión y se determina que sus beneficios por incapacidad permanente son desproporcionadamente bajos, es posible que usted califique para recibir dinero adicional del Fondo para la reintegración al trabajo del Departamento de

Relaciones Laborales (*Department of Industrial Relations*). Comuníquese con el Departamento de Relaciones Laborales en: www.dir.ca.gov/ para conocer más acerca de este beneficio adicional.

Es posible que las actividades como voluntario, en sus horas libres, recreacionales, sociales o atléticas no estén cubiertas bajo la compensación laboral.

Si se lastima:

Obtenga atención médica. Si necesita primeros auxilios, comuníquese con su empleador. Si necesita atención urgente, pida ayuda de inmediato.

Informe sobre su lesión. Informe de inmediato a su supervisor sobre su lesión. No demore en hacerlo; existen límites de tiempo. Si espera demasiado, puede perder los derechos que tiene a recibir beneficios. Su empleador tiene que proporcionarle un formulario de reclamación a más tardar un día laborable después de que esté enterado de su lesión, y también debe autorizar el tratamiento a más tardar un día laborable después de que usted le entregue una copia del formulario lleno y firmado. El plazo de prescripción para presentar una reclamación de compensación laboral es de un año a partir de la fecha de la lesión o, si esta se debe a exposiciones repetidas, un año a partir del momento en que usted se dio cuenta o debió darse cuenta de que su trabajo causó la lesión.

Vea a su médico tratante. Su médico tratante primario es el médico con la responsabilidad global de tratar su lesión o enfermedad. Él o ella están a cargo de mantener la continuidad de su atención, así como de remitirlo a los especialistas. Si su empleador tiene una Red de Proveedores Médicos (MPN, por sus siglas en inglés) aprobada, es posible que ellos puedan limitar sus opciones de médicos tratantes, que retengan el control médico, y que le exijan que se atienda con un médico de la MPN desde el principio. (Una MPN es una red escogida de proveedores de atención médica que proveen tratamiento a los empleados que se lesionan en el trabajo. Consulte con su empleador para obtener más información sobre su MPN). De lo contrario, su empleador tiene el derecho de escoger el médico que lo tratará a usted por los primeros 30 días. Si su empleador no tiene una MPN aprobada y usted desea cambiar de médico en los primeros 30 días después de presentar su reclamación, su administrador de reclamaciones debe escoger un médico nuevo en un lapso de cinco días después de que usted lo solicite.

Si usted le proporcionó a su empleador el nombre de su médico personal antes de sufrir la lesión y tiene seguro médico de grupo al momento de la lesión, usted puede tratarse con su médico personal incluso si su empleador tiene una MPN aprobada. Su médico personal debe ser un médico general o un médico internista, pediatra, ginecobstetra o médico de familia con certificado de especialidad o que haya completado su especialidad, o un grupo médico con múltiples especialidades con doctores o licenciados en medicina, y debe haberlo tratado y tener sus antecedentes médicos y su historia clínica antes de su lesión laboral y también debe estar de acuerdo en tratarlo por una lesión o enfermedad laboral. Si su empleador no tiene una MPN aprobada y usted le dio a su empleador por escrito el nombre de su quiropráctico o acupunturista personal antes de sufrir la lesión, usted puede cambiarse al quiropráctico o acupunturista cuando lo solicite. Si todavía necesita recibir atención médica luego de 30 días, quizás pueda cambiarse a un médico de su propia elección.

Para mayor comodidad, se adjuntan a este documento formularios opcionales para predesignar a su médico personal o a un grupo médico con múltiples especialidades con doctores o licenciados en medicina. También se adjuntan formularios para predesignar a su acupunturista o quiropráctico personal si su empleador no cuenta con una red de proveedores médicos. Por ley, no se permite que los quiroprácticos sean el médico tratante luego de 24 visitas.

Discriminación: Es ilegal que su empleador lo castigue o lo despida por sufrir una lesión o enfermedad laboral, por presentar una reclamación, o por testificar en el caso de compensación laboral de otra persona. Si se determina que su empleador ha cometido discriminación, usted puede tener derecho a que se le reincorpore a su puesto de trabajo con pagos retroactivos, una mayor compensación, y costos y gastos. Es posible que usted tenga otros derechos bajo la Ley de Protección para Personas Discapacitadas (ADA, por sus siglas en inglés) o la Ley de Igualdad en el Empleo y la Vivienda (FEHA, por sus siglas en inglés). Para obtener más información, comuníquese con FEHA al (800) 884-1684 o con la Comisión de Igualdad de Oportunidades Laborales (EEOC, por sus siglas en inglés) al (800) 669-3362. Puede obtener información gratuita de un funcionario de información y ayuda de la División de Compensación Laboral de su estado. Puede escuchar información grabada y una lista de las oficinas locales llamando sin costo al **(800) 736-7401** o averiguar más en línea en: **http://www.dir.ca.gov**.

Si su empleador no le proporciona atención médica, usted tiene varias opciones. Primero, comuníquese con su administrador de reclamaciones para averiguar el estado de su reclamación. Si le entregó a su empleador un formulario de reclamación lleno y firmado pero su reclamación está retrasada por la investigación, su empleador tiene que autorizar el tratamiento, hasta un máximo de $10,000.00, durante el retraso. Si todavía no se ha aceptado la reclamación y sus costos médicos sobrepasan el límite reglamentario de $10,000.00, usted puede acudir a su plan médico de grupo para recibir atención, buscar un médico, una clínica o un hospital que le facture directamente al administrador de reclamaciones, o utilizar los servicios públicos de atención médica.

Usted tiene derecho a estar en desacuerdo con las decisiones que afectan su reclamación. Si está en desacuerdo, comuníquese primero con su administrador de reclamaciones para ver si lo pueden resolver.

Su compañía de seguros de compensación laboral es **Travelers Property Casualty Company of America**.

También puede buscar su compañía de seguros en el directorio en línea de WCIRB:
https://www.caworkcompcoverage.com/

Puede obtener información gratuita de un funcionario de Información y Ayuda de la División de Compensación Laboral de su estado, o puede escuchar información grabada y una lista de las oficinas locales llamando al **(800) 736-7401**. Al final de este folleto, encontrará una lista de las oficinas de Información y Ayuda. Esto lo ayudará a localizar la oficina más cerca de usted. Para más información, también puede visitar el sitio web del DWC en: **http://www.dir.ca.gov**.

Puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratuita. Si decide contratar un abogado, es posible que los honorarios se saquen de algunos de sus beneficios. Para obtener los nombres de los abogados especializados en compensación laboral, llame al Colegio de Abogados del estado de California al (415) 538-2120 o visite su sitio web en: **http://www.californiaspecialist.org**. El funcionario local de información y ayuda puede proporcionarle una lista de los abogados o usted puede buscarlos en las páginas amarillas.

Designación Previa De Médico Particular

En caso de que usted sufra una lesión o enfermedad relacionada con su empleo, usted puede recibir tratamiento médico por esa lesión o enfermedad de su médico particular (M.D.), médico osteópata (D.O.) o grupo médico si:

- en la fecha de su lesión de trabajo, usted tiene cobertura de salud por lesiones o enfermedades que no están relacionado con el trabajo
- el médico es su médico familiar o de cabecera, que será un médico que ha limitado su práctica médica a medicina general o que es un internista certificado o elegible para certificación, pediatra, gineco-obstreta, o médico de medicina familiar y que previamente ha estado a cargo de su tratamiento médico y tiene su expediente médico
- su "médico particular" puede ser un grupo médico si es una corporación o sociedad o asociación compuesta de doctores certificados en medicina u osteopatía, que opera un integrado grupo médico multidisciplinario que predominantemente proporciona amplios servicios médicos para lesiones y enfermedades no relacionadas con el trabajo.
- antes de la lesión su médico está de acuerdo a proporcionarle tratamiento médico para su lesión o enfermedad de trabajo • antes de la lesión usted le proporcionó a su empleador por escrito lo siguiente: (1) notificación de que quiere que su médico particular le brinde tratamiento para una lesión o enfermedad de trabajo y (2) el nombre y dirección comercial de su médico particular.

Puede utilizar este formulario para notificarle a su empleador que desea que su médico particular o médico osteópata lo atienda para una lesión o enfermedad de trabajo y que los requisitos mencionados arriba han sido cumplidos.

NOTICIA DE DESIGNACIÓN PREVIA DE MÉDICO PARTICULAR

Empleado: Llene esta sección.

A:_____
(nombre del empleador) Si tengo una lesión o enfermedad de trabajo, yo elijo ser atendido por:

_____
(nombre del médico) (M.D., D.O., o grupo médico)

_____(dirección, ciudad, estado, código postal)

_____(número de teléfono)

Nombre del Empleado (en letras de molde, por favor):

_____

Domicilio del Empleado:

_____

Nombre de la Compañía de Seguros, Plan o Fondo de proporcionar cobertura de salud para lesiones o enfermedades no ocupacionales:

_____

Firma del Empleado:_____ Fecha:_____

Médico: Estoy de acuerdo con esta Designación Previa:

Firma:_____ Fecha:_____
(Médico o Empleado designado por el Médico o Grupo Médico)

El médico no está o bligado a firmar este formul ario, sin embargo, si el médico o empl eado designado por el médico o grupo médico no firma, será n ecesario presentar documentación sobre el consentimiento del médico de ser designado previamente de acuerdo al Código de Reglamentos de California, Tí tulo 8, sección 9780.1 (a) (3).

Tí tulo 8, Código de Regulaciones de California, sección 9783
Opcional Formulario DW C 9783, Fecha de vigencia 1 de Julio 2014
Designación Previa del Médico Personal;Obligaciones de Información de la prima ria El tratamiento médico
Reglamentos 8 CCR Sección 9780, et seq. (Aprobado 12/02/2014)

AVISO DE QUIROPRÁCTICO PERSONAL O ACUPUNTURISTA PERSONAL

Si su empleador o la compañía de seguros de su empleador no tiene una Red de Proveedores Médicos establecida, posiblemente puede cambiar su médico que lo está atendiendo a su quiropráctico o acupunturista personal después de una lesión o enfermedad de trabajo. Para hacer este cambio, usted debe darle por escrito a su empleador el nombre y la dirección comercial de un quiropráctico o acupunturista personal antes de la lesión o enfermedad. Generalmente, su administrador de reclamos tiene el derecho de elegir al médico que le proporcionará el tratamiento dentro de los primeros 30 días después de que su empleador sepa de su lesión o enfermedad. Después de que su administrador de reclamos ha iniciado su tratamiento con otro médico durante este tiempo, puede entonces usted, bajo petición, transferir su tratamiento a su quiropráctico o acupunturista personal.

NOTA: Si la fecha de la lesión es el 1 de enero de 2004 o posterior, un quiropráctico no puede ser su médico tratante después de haber recibido 24 visitas al quiropráctico a menos que su empleador ha autorizado visitas adicionales por escrito. El término "visita quiropráctica", cualquier visita a la oficina de la quiropráctica, independientemente de si los servicios prestados implican la manipulación quiropráctica o se limitan a la evaluación y gestión. Una vez que haya recibido 24 visitas al quiropráctico, si aún necesita tratamiento médico, usted tendrá que elegir un nuevo médico que no es un quiropráctico. Esta prohibición no se aplicará a las visitas para las visitas de medicina física posquirúrgicos prescritos por el cirujano o un médico designado por el cirujano, en el marco del componente posquirúrgica de la División de Tratamiento Médico programa de utilización de Compensación para Trabajadores.

Puede utilizar este formulario para notificarle a su empleador de su quiropráctico o acupunturista personal.

Información sobre su Quiropráctico o Acupunturista:

_____

(nombre del quiropráctico o acupunturista)

_____

(dirección, ciudad, estado, código postal)

_____

(número de teléfono)

_____

Nombre del Empleado (en letras de molde, por favor):

Domicilio del Empleado:

_____

Firma del Empleado:_____ **Fecha:** _____

Tí tulo 8, Código de Regulaciones de California, sección 9783.1

(Opcional Formulario DW C 9783.1, Fecha de vigencia 1 de Julio 2014)

Designación Previa del Médico Personal;Obligaciones de Información del Médico Primario

Regulaciones 8 C.C.R. Sección 9780,et seq. (Aprobado 12/02/2014)

Comuniquese con la unidad de información y ayuda

- Por teléfono al 1-800-736-7401: Para obtener información grabada que ayuda a los trabajadores lesionados, los empleadores y otras personas a entender el sistema de compensación laboral de California, y sus derechos y responsabilidades conforme a la ley.
- Asistiendo a un taller para trabajadores lesionados
- Llamando o yendo en persona a una oficina local de la Unidad de información y ayuda:

Anaheim 1065 N. PacifiCenter Drive Anaheim, CA 92806 (714) 414-1801	**Oxnard** 1901 N. Rice Ave., Ste. 200 Oxnard, CA 93036 (805) 485-3528	**San Francisco** 455 Golden Gate Avenue, 2nd floor San Francisco, CA 94102-7014 (415) 703-5020
Bakersfield 1800 30th Street, Suite 100 Bakersfield, CA 93301-1929 (661) 395-2514	**Pomona** 732 Corporate Center Drive Pomona, CA 91768-2653 (909) 623-8568	**San Jose** 100 Paseo de San Antonio Room 241 San Jose, CA 95113-1402 (408) 277-1292
Eureka 100 "H" Street, Room 202 Eureka, CA 95501-0481 (707) 441-5723	**Redding** 25o Hemsted-Drive, 2nd Floor, Ste. B Redding, CA 96002 (530) 225-2047	**San Luis Obispo** 4740 Allene Way, Suite 100 San Luis Obispo, CA 93401 (805) 596-4159
Fresno 2550 Mariposa Mall, Suite 4078 Fresno, CA 93721-2219 (559) 445-5355	**Riverside** 3737 Main Street, Room 300 Riverside, CA 92501-3337 (951) 782-4347	**Santa Ana** 605 W Santa Ana Blvd Bldg 28, Room 451 Santa Ana, CA 92701 (714) 558-4597
Long Beach 300 Oceangate Street, Suite 200 Long Beach, CA 90802-4304 (562) 590-5240	**Sacramento** 160 Promenade Circle, Suite 300 Sacramento, CA 95834 (916) 928-3158	**Santa Barbara** Satellite Office 130 E. Ortega Street Santa Barbara, CA 93101-1631 (805) 884-1032
Los Angeles 320 W. 4th Street, 9th floor Los Angeles, CA 90013-2329 (213) 576-7389	**Salinas** 1880 North Main Street, Suite 100 Salinas, CA 93906-2037 (831) 443-3058	**Santa Rosa** 50 "D" Street, Room 420 Santa Rosa, CA 95404-4771 (707) 576-2452
Marina del Rey 4720 Lincoln Blvd, 2nd &3rd floors Marina del Rey, CA 90292-6902 (310) 482-3858	**San Bernardino** 464 W. Fourth Street, Suite 239 San Bernardino, CA 92401-1411 (909) 383-4522	**Stockton** 31 East Channel Street, Room 344 Stockton, CA 95202-2314 (209) 948-7980
Oakland 1515 Clay Street, 6th floor Oakland, CA 94612 (510) 622-2861	**San Diego** 7575 Metropolitan Drive, Suite 202 San Diego, CA 92108 (619) 767-2082	**Van Nuys** 6150 Van Nuys Blvd., Room 105 Van Nuys, CA 91401-3370 (818) 901-5367

ISSUE TO: **CHAMPLAIN COLLEGE INCORPORATED**

STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation

Notice to Employees – Injuries Caused By Work

You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures (such as hurting your wrist from doing the same motion over and over).

Benefits. Workers' compensation benefits include:

- **Medical Care:** Doctor visits, hospital services, physical therapy, lab tests, x-rays, medicines, medical equipment and travel costs that are reasonably necessary to treat your injury. You should never see a bill. There are limits on chiropractic, physical therapy and occupational therapy visits.
- **Temporary Disability (TD) Benefits:** Payments if you lose wages while recovering. For most injuries, TD benefits may not be paid for more than 104 weeks within five years from the date of injury.
- **Permanent Disability (PD) Benefits:** Payments if you do not recover completely and your injury causes a permanent loss of physical or mental function that a doctor can measure.
- **Supplemental Job Displacement Benefit:** A nontransferable voucher, if you are injured on or after 1/1/2004, your injury causes permanent disability, and your employer does not offer you regular, modified, or alternative work.
- **Death Benefits:** Paid to your dependents if you die from a work-related injury or illness.

Naming Your Own Physician Before Injury or Illness (Predesignation). You may be able to choose the doctor who will treat you for a job injury or illness. If eligible, you must tell your employer, in writing, the name and address of your personal physician or medical group before you are injured. You must obtain their agreement to treat you for your work injury. For instructions, see the written information about workers' compensation that your employer is required to give to new employees.

If You Get Hurt:

1. **Get Medical Care.** If you need emergency care, call 911 for help immediately from the hospital, ambulance, fire department or police department. If you need first aid, contact your employer.
2. **Report Your Injury.** Report the injury immediately to your supervisor or to an employer representative. Don't delay. There are time limits. If you wait too long, you may lose your right to benefits. Your employer is required to provide you with a claim form within one working day after learning about your injury. W ithin one working day after you file a claim form, your employer or claims administrator must authorize the provision of all treatment, up to ten thousand dollars, consistent with the applicable treatment guidelines, for your alleged injury until the claim is accepted or rejected.
3. **See Your Primary Treating Physician (PTP).** This is the doctor with overall responsibility for treating your injury or illness.
   - If you predesignated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
   - If your employer is using a medical provider network (MPN) or a health care organization (HCO), in most cases you will be treated within the MPN or HCO unless you predesignated a personal physician or medical group. An MPN is a group of physicians and health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
   - If your employer is not using an MPN or HCO, in most cases the claims administrator can choose the doctor who first treats you when you are injured, unless you predesignated a personal physician or medical group.
4. **Medical Provider Networks.** Your employer may be using an MPN, which is a group of health care providers designated to provide treatment to workers injured on the job. If you have predesignated a personal physician or medical group prior to your work injury, then you may go there to receive treatment from your predesignated doctor. If you are treating with a non-MPN doctor for an existing injury, you may be required to change to a doctor within the MPN. For more information, see the MPN contact information below:

MPN website: **WWW.MYWCINFO.COM**

MPN Effective Date: **02-15-22** MPN Identification number **2493**

If you need help locating an MPN physician, call your MPN access assistant at: **(800) 287-9682**

If you have questions about the MPN or want to file a complaint against the MPN, call the MPN Contact Person at **(800) 287-9682**

Discrimination. It is illegal for your employer to punish or fire you for having a work injury or illness, for filing a claim, or testifying in another person's workers' compensation case. If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Questions? Learn more about workers' compensation by reading the information that your employer is required to give you at time of hire. If you have questions, see your employer or the claims administrator (who handles workers' compensation claims for your employer):

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

Claims Administrator **THE TRAVELERS INSURANCE COMPANIES** Phone **(800) 238-6225**

W orkers' compensation insurer _____ (Enter "self-insured" if appropriate)

You can also get free information from a State Division of W orkers' Compensation Information (DWC) & Assistance Officer. The nearest Information & Assistance Officer can be found at location: _____ or by calling toll-free **(800) 736-7401**. Learn more information about workers' compensation online: www.dwc.ca.gov and access a useful booklet "Workers' Compensation in California: A Guidebook for Injured W orkers."

False claims and false denials. Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony and may be fined and imprisoned.

Your employer may not be liable for the payment of workers' compensation benefits for any injury that arises from your voluntary participation in any **off-duty, recreational, social, or athletic activity** that is not part of your work-related duties.

DWC 7 (1/1/2016)

W04P2K16

ISSUE TO: **CHAMPLAIN COLLEGE INCORPORATED**

ESTADO DE CALIFORNIA – DEPARTAMENTO DE RELACIONES INDUSTRIALES

División de Compensación de Trabajadores

Aviso a los Empleados – Lesiones Causadas por el Trabajo

Es posible que usted tenga derecho a beneficios de compensación de trabajadores si usted se lesiona o se enferma a causa de su trabajo. La compensación de trabajadores cubre la mayora de las lesiones y enfermedades físicas o mentales relacionadas con el trabajo. Una lesión o enfermedad puede ser causada por un evento (como por ejemplo lastimarse la espalda en una ca da) o por acciones repetidas (como por ejemplo lastimarse la muñeca por hacer el mismo movimiento una y otra vez).

Beneficios. Los beneficios de compensación de trabajadores incluyen:

- **Atención Médica:** Consultas médicas, servicios de hospital, terapia física, análisis de laboratorio, radiografías, medicinas, equipo médico y costos de viajar que son razonablemente necesarias para tratar su lesión. Usted nunca deberá ver un cobro. Hay límites para visitas quiroprácticas, de terapia física y de terapia ocupacional.
- **Beneficios por Incapacidad Temporal (TD):** Pagos si usted pierde sueldo mientras se recupera. Para la mayora de las lesiones, beneficios de TD no se pagarán por más de 104 semanas dentro de cinco años después de la fecha de la lesión.
- **Beneficios por Incapacidad Permanente (PD):** Pagos si usted no se recupera completamente y si su lesión le causa una pérdida permanente de su función física o mental que un médico puede medir.
- **Beneficio Suplementario por Desplazamiento de Trabajo:** Un vale no-transferible si su lesión surge en o después del 1/1/04, y su lesión le ocasiona una incapacidad permanente, y su empleador no le ofrece a usted un trabajo regular, modificado, o alternativo.
- **Beneficios por Muerte:** Pagados a sus dependientes si usted muere a causa de una lesión o enfermedad relacionada con el trabajo.

Designación de su Propio Médico Antes de una Lesión o Enfermedad (Designación previa). Es posible que usted pueda elegir al médico que le atenderá en una lesión o enfermedad relacionada con el trabajo. Si elegible, usted debe informarle al empleador, por escrito, el nombre y la dirección de su médico personal o grupo médico, *antes* de que usted se lesione. Usted debe de ponerse de acuerdo con su médico para que atienda la lesión causada por el trabajo. Para instrucciones, vea la información escrita sobre la compensación de trabajadores que se le exige a su empleador darle a los empleados nuevos.

Si Usted se Lastima:

1. **Obtenga Atención Médica.** Si usted necesita atención de emergencia, llame al 911 para ayuda inmediata de un hospital, una ambulancia, el departamento de bomberos o departamento de policía. Si usted necesita primeros auxilios, comuníquese con su empleador.
2. **Reporte su Lesión.** Reporte la lesión inmediatamente a su supervisor(a) o a un representante del empleador. No se demore. Hay límites de tiempo. Si usted espera demasiado, es posible que usted pierda su derecho a beneficios. Su empleador está obligado a proporcionarle un formulario de reclamo dentro de un día laboral después de saber de su lesión. Dentro de un día después de que usted presente un formulario de reclamo, el empleador o administrador de reclamos debe autorizar todo tratamiento médico, hasta diez mil dólares, de acuerdo con las pautas de tratamiento aplicables a su presunta lesi n, hasta que el reclamo sea aceptado o rechazado.
3. **Consulte al Médico que le está Atendiendo (PTP).** Este es el médico con la responsabilidad total de tratar su lesión o enfermedad.
   - Si usted designó previamente a su médico personal o grupo médico, usted puede consultar a su médico personal o grupo médico después de lesionarse.
   - Si su empleador está utilizando una Red de Proveedores Médicos (MPN) o una Organización de Cuidado Médico (HCO), en la mayoría de los casos usted será tratado dentro de la MPN o la HCO a menos que usted designó previamente un médico personal o grupo médico. Una MPN es un grupo de médicos y proveedores de atención médicaque proporcionan tratamiento a trabajadores lesionados en el trabajo. Usted debe recibir informaci n de su empleador si est cubierto por una HCO o una MPN. Hable con su empleador para más información.
   - Si su empleador no está utilizando una MPN o HCO, en la mayoría de los casos el administrador de reclamos puede escoger el médico que lo atiende primero, cuando usted se lesiona, a menos que usted designó previamente a un médico personal o grupo médico.
4. **Red de Proveedores Médicos (MPN):** Es posible que su empleador use una MPN, lo cual es un grupo de proveedores de asistencia médica designados para dar tratamiento a los trabajadores lesionados en el trabajo. **Si usted ha hecho una designación previa de un médico personal antes de lesionarse en el trabajo, entonces usted puede recibir tratamiento de su médico previamente designado.** Si usted está recibiendo tratamiento de parte de un médico que no pertenece a la MPN para una lesión existente, puede querirse que usted se cambie a un médico dentro de la MPN. Para más información, vea la siguiente información de contacto de la MPN:

Página web de la MPN: **WWW.MYWCINFO.COM**

Fecha de vigencia de la MPN: **02-15-22** Número de identificación de la MPN: **2493**

Si usted necesita ayuda en localizar un médico de una MPN, llame a su asistente de acceso de la MPN al: **(800) 287-9682**

Si uste d tie ne pre gunta s sobre la MPN o quiere presentar una queja en contra de la MPN, llame a la Persona de Contacto de la MPN al :

(800) 287-9682

Discriminación. Es ilegal que su empleador le castigue o despida por sufrir una lesión o enferm edad en el trabajo, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los lí mites establecidos por el estado.

¿Preguntas? Aprenda más sobre la compensación de trabajadores leyendo la información que se requiere que su empleador le dé cuando es contratado. Si usted tiene preguntas, vea a su empleador o al administrador de reclamos (que se encarga de los reclamos de compensación de trabajadores de su empleador):

Administrador de Reclamos **TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA THE TRAVELERS INSURANCE COMPANIES** Teléfono **(800) 238-6225**

Asegurador del Seguro de Compensación de trabajador _____ (Anote "autoasegurado" si es apropiado)

Usted también puede obtener información gratuita de un Oficial de Información y Asistencia de la División Estatal de Compensación de Trabajadores. El Oficial de Información y Asistencia más cercano se localiza en: _____

o llamando al número gratuito **(800) 736-7401**. Usted puede obtener más información sobre la compensación del trabajador en el Internet en: **www.dwc.ca.gov** y acceder a una guía útil "Compensación del Trabajador de California Una Guía para Trabajadores Lesionados."

Los reclamos falsos y rechazos falsos del reclamo. Cualquier persona que haga o que ocasione que se haga una declaración o una representación material intencionalmente falsa o fraudulenta, con el fin de obtener o negar beneficios o pagos de compensacón de trabajadores, es culpable de un delito grave y puede ser multado y encarcelado.

Es posible que su empleador no sea responsable por el pago de beneficios de compensación de trabajadores para ninguna lesión que proviene su participación voluntaria en cualquire **actividad fuera del trabajo, recreativa, social, o atlética** que no sea parte de sus deberes laborales.