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

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

RATE BUREAU ID: 911451999

EXP. MOD. EFFECTIVE DATE: 02-15-22

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 FL- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	282639.00	0.40	1131

FL MANUAL PREMIUM $ 1131

1.10% EMPL. LIAB. INCREASED LIMITS(9807)	$ 12
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	1143
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM	743
-8.20% PREMIUM DISCOUNT(0063)	-61
TERRORISM(9740)	28
TOTAL ESTIMATED PREMIUM	710
TOTAL PREMIUM	710
DEPOSIT AMOUNT DUE	710

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 09 06 07 (A)

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

FLORIDA WORKERS COMPENSATION INSURANCE GUARANTY ASSOCIATION SURCHARGE ENDORSEMENT

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

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

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

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

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

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

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

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

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

Schedule

Surcharge rate 0.00 %

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

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

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by_____

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

FLORIDA TERRORISM RISK INSURANCE PROGRAM REAUTHORIZATION ACT ENDORSEMENT

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

Definitions

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

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

Limitation of Liability

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

Policyholder Disclosure Notice

1. Insured Losses would be partially reimbursed by the United States Government. If the aggregate industry Insured Losses occurring in any calendar year exceed $200,000,000, the United States Government would pay 80% of our Insured Losses that exceed our Insurer Deductible.
2. Notwithstanding item 1 above, the United States Government may not have to make any payment under the Act for any portion of Insured Losses that exceed $100,000,000,000.

3. The premium charged for the coverage for Insured Losses under this policy is included in the amount shown in Item 4 of the Information Page or the Schedule below.

Schedule

$ 0.01 per $100 of Remuneration

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 09 03 03 (00)

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

FLORIDA EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

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

This insurance does not cover

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

TRAVELERS
ONE TOWER SQUARE
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POLICY NUMBER: UB-6N259033-22-14-G

FLORIDA NON-COOPERATION WITH PREMIUM AUDIT ENDORSEMENT

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

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

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

1. We make two good faith efforts to obtain the voluntary audit report or complete the physical audit.
2. We document the audit file regarding the above attempts to obtain the required audit information.
3. After the two good faith attempts to obtain records, we send a letter by certified mail to you advising you of the specific records that are required and the premium that will be charged if you continue to refuse access to the records.

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

This endorsement changes the policy 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 09 06 06 (00)

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

FLORIDA EMPLOYMENT AND WAGE INFORMATION RELEASE ENDORSEMENT

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

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

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

NOTICE OF ELECTION TO ACCEPT A BENEFIT DEDUCTIBLE AND/OR COINSURANCE PROGRAM FOR WORKERS' COMPENSATION COVERAGE IN FLORIDA

Florida Policyholders

The Florida law now permits an employer to buy Workers' Compensation Insurance with a deductible coinsurance or in a deductible coinsurance combined option. The program is applied to indemnity and medical benefits and applies separately to each accident during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum and a maximum for each accident, depending which program is selected.

Effective January 1, 1994 the State of Florida passed in special session a $2,500 State Authorized deductible. Any amount paid by the employer in this deductible option (4) shall reduce the amount of loss that goes into Experiencing Rating of such employer. There is no premium credit applied to this program.

To prevent putting you in an uninsured position, your policy has been issued at full rates without this program being applied.

If you wish to have one of the options apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement will then be attached to your policy to reflect the change.

If you decide that you do not want this benefit deductible and/or coinsurance program to apply, or if you already have it on the policy, you may disregard this form. Your policy will continue in force as issued.

For a complete explanation of how this program operates or the savings available by choosing one of these options, please contact your agent.

DATE OF ISSUE: **02-14-22**

Item #1: PROGRAM _____

AMOUNT _____

Item #2:

Program 1 - Coinsurance/Deductibles		Program 2 - Coinsurance	
Deductible Amount w/$21,000 Coinsurance	Policy Premium Reduction	Coinsurance Amount	Policy Premium Reduction
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker	$ 5,000 10,000 15,000 20,000 21,000	See Your Agent/ Broker
Use Florida Coinsurance and Deductible Endorsement WC 09 06 03.		Use Florida Deductible Endorsement WC 09 06 04.	
Program 3 - Deductibles		**Program 4 - Deductible**	
Deductible Amount	Policy Premium Reduction	Deductible $2,500 (No Policy Premium Credit)	
$ 500 1,000 1,500 2,000 2,500	See Your Agent/ Broker		
Use Florida Benefits Deductible Endorsement WC 09 06 05.		Use Florida Benefits Deductible Endorsement WC 09 06 05.	

Yes, I want the program/amount that I selected in Item #1 to be applied to my policy for medical and indemnity benefits under the Florida Workers' Compensation Law. I understand that the company shall pay the deductible or coinsurance amount and seek reimbursement from the employer shown below.

I understand that in accordance with Florida Laws, I have the option of modifying the above program choice at the time of renewal of my Workers' Compensation policy with the insurance company named below.

Date: _____ Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

DATE OF ISSUE: **02-14-22**

IMPORTANT NOTICE

TO ALL COMMERCIAL CASUALTY AND/OR COMMERCIAL PROPERTY POLICYHOLDERS DOING BUSINESS IN THE STATE OF FLORIDA

Florida loss control insurance statutes require insurers to provide commercial policyholders, at their request, with guidelines for risk management plans. Travelers Risk Control Department has available guidelines to assist you with your accident prevention activities. These guidelines are available to you free of charge.

The risk management program shall include safety measures, including, as applicable, pollution and environmental hazards, disease hazards, accidental occurrences, fire hazards and fire prevention and detection, liability for acts from the course of business, slip and fall hazards, product injury, and hazards unique to a particular class or category of insureds.

Training in safety management techniques and safety management counseling services are also available.

If you would like to request assistance with risk management or your safety program, please call our Risk Control department at 800-973-9215. For access to over 1,000 safety and health resources, including training programs, checklists, management guides, etc., log in at www.travelers.com. Not registered? Select "Log In" and then "Register Now" to register for MyTravelers for Business.

IMPORTANT WORKERS COMPENSATION INFORMATION FOR FLORIDA'S EMPLOYERS – EMPLOYER FACTS

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

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

Workers' Compensation Notice

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

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

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

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

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers' compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance companies have a toll-free number to report work-related injuries. If you report the injury or illness to the insurance carrier by telephone, the carrier will complete the form and send a copy to you and the employer within three business days. You can also fill out the First Report of Injury or Illness form (DWC-10) and send it to the insurance carrier. The form contains employer, employee and accident information and can be obtained on the Division of Workers' Compensation Web site at www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1.pdf. You must also provide a copy of the First Report of Injury or Illness form to the employee. The employee's signature on the form is preferred, but if the employee is not able or available to sign it, then write "not available" in the employee signature box.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers' compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-413-1980. To access the form, go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1.

Medical Benefits

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

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

Authorized treatment and care may include:

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

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

Wage Replacement Benefits

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

- Temporary Total Benefits. These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.
- Temporary Partial Benefits. These benefits are provided when the doctor releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.
- Permanent Impairment Benefits. These benefits are provided when the injury causes any physical psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a while. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.
- Permanent Total Benefits. These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.
- Death Benefits. Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits 9each are subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

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

Employee Assistance Office

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

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

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

Petition for Benefits

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

Anti-Fraud Reward Program

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

Workers Compensation Exemptions

Construction Industry

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

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

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

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

Non-Construction Industry

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

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

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

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

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

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

What Your Employee Can Expect From the Insurance Carrier

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

Questions about workers' compensation?

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

Employee Assistance and Ombudsman Office Hotline

1-800-342-1741

Injured worker e-mail inquiries

wceao@MyFloridaCFO.com

Customer Service

(850) 413-1601

Employer e-mail inquires

WorkCompCustServ@MyFloridaCFO.com

Workers' Compensation Fraud Hotline

1-800-378-0445

Frequently Asked Questions

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

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

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

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

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

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

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

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

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

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

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

Disclaimer:

This publication is being offered as an informational tool only and complies with s.440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 39L-3.025, F.A.C. Forms
DFS-F2-DWC-65
Revised March 2010

INFORMATIÓN IMPORTANTE DEL SEGUOR DE INDEMNIZATION POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA – INFORMATIÓN PARA EMPLEADORES

Su póliza de seguro por accidents de trabajo curbre beneficios médicos y reemploazo parcial del salario para cualquier empleado que sostenga lesion o una enfermedad relacionada con su trabajo.

Este folleto le dará una major comprensión de su papel y responsabilidades bajo el Sistema de seguro por accidents de trabajo.

Aviso de seguor por accidents de trabajo

La ley require qua cada empleador que ha adquirido una póliza de seguro por accidents de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañia de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La Division de Compensaction por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañies de seguro se las proporcionen a sus asequrados. Su compania de seguros tiene obligation legal de proveerle los cartels.

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

- Subestimar u ocultar nómina de pago.
- Falsificar u ocultara las responsabilidades del empleado para evitar la classificación apropriada para los calculus de la prima de seguro
- Falsificar u ocultar información pertinente al cálculo y aplicación de un factor de modificación de experiencia

Los empleadores que tienen obligación de proveer seguro por accidents de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidents de trabajo, son sujetos, a recibit una orden de suspension de trabajo y penas civiles y criminals.

Primer reporte de la lesion o enfermedad

Tan pronto usted se entere de una lesion o enfermedad relacionada con un accidente en el lugar de trabajo, contacte inmediatamente a su compañia de seguro por accidents de trabajo. Si usted no reporta la lesion o la enfermedad a la compañia de seguro en un plazo de siete dias despues de la fecha que usted fue informado, usted puede estar sujeto a una multa administrative que no exceda $2,000 por ocurrencia. La mayoría de las companies de seguros tienen un número gratis para reporter lesions relacionadas con el trabajo. Si usted reporta la lesion o la enfermedad a la compañia de seguros por teléfono, la compañia de seguros llenará el formulario y le enviará una copia al empleado debtor de tres dias laborales. Usted también puede completer el primer reporte de la lesion o enferemedad (DWC-1) y enviarlo a la compañia de sequros. El formulario contiene información sobre el empleador, el empleado, y el accidente y se puede obtener en la página Web de la División de Compensación por Accidentes de Trabajo en www.MyFloridaCFO.com/WC/pdf/DFS-F2-DWC-1a.pdf. Usted debe también proveer una copia del primer reporte del accidente o enfermedad al empleado. Se prefiere la firma del empleado en al formulario, pero si el empleado no puede o no esta disponible para firmarlo, escriba "no disponible" en la caja donde se pide la firma del empleado.

Fallecimientos relacionados con el trabajo

Empleadores también tienen que reporter muertas que resulten por lesions o enfermedades relacionadas con el trabajo a la División de Compensación por Accidentes de Trabajo en un plazo de 24 horas. Para reporter una fatalidad en el lugar de trabajo, llame al 1-800-219-8953 (en la Florida) o al 850-413-1611, o envie el primer reporte de la lesión o enfermedad con la informatión sobre la muerte por fax a 850-413-1980. Para tener acceso al formulario, vaya a la página web http://www.MyFloridaCFO.com/WC/forms.html. Haga clic en DWC-1.

Beneficios médicos

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

- Determinará si la lesión es compensable

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

Atención médica y tratamientos autorizados pueden incluir:

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

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

Beneficios de reemplazo de salario

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

- Beneficios Por incapacidad total temporal (TTD por su sigla en Inglés): Estos beneficios son proveidos como resultado de una lesión o enfermedad que temporalmente prohibe que el empleado vuelva a trabajar, y el empleado no ha alcanzado la maxima mejoría médica.
- Beneficios Por incapacidad parcial temporal (TPD por su sigla en Inglés): Estos beneficios son proveldos cuando el médico le permite al empleado volver a trabajar, el empleado no ha alcanzado la maxima mejoría médica, y gana menos del 80% del salrio que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión. El period máximo que el empleado lesionado puede recibir beneficios temporalis es 104 semanas o hasta que la fecha del MMI sea determinada, lo que ocurra primero..
- Beneficios por daños permanente (IB por su sigla en Inglés) Estos beneficios son proveldos cuando la lesión o enfermedad causa cualquier pérdida fisica, psicológica o functional y el impedimento existe después de la fecha de la maxima mejoría médica (MMI). Un médico asignará una valoración de incapacidad permanente a la lesión que sera expresada como un porcentaje.
- Beneficios por incapacidad total permanente (PTD por su sigla en Inglés): Estos beneficios son proveidos cuando la lesión causa que el empleado sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley .
- Indemnizaciones por fallecimiento: Compensación por accidents de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a limites definidos por ley). Un cónyuge dependiente puede sere legible para entrenamiento vocacional.

Formulario de la declaración del salario

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

Oficina de ayuda al trabajador

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

Los especialistas de la EAO poseen conocimiento sobre el Sistema de seguro por accidents de trabajo y pueden contester sus preguntas. EAO tiene oficinas por todo el estado que puede llamar o visitor. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Además, la División de Compensación por Accidentes de Trabajo tiene una sección en el Web, "Preguntas heches con frecuencia por empleadores," que puede alcanzar en: http://www.MyFloridaCFO.com/WC/faq/faqemplyrs.html.

Petición para beneficios

Para comenzar el proceso judicial para solicitor beneficios que se le deben según la ley pero la compañia de seguros no lo ha proveldo, se debe presenter el formulario "Petition for Benefits" [Petición para beneficios] a la Oficina de Los Jueces de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/forms.asp.

Programa de recompensación contra fraude

El fraude en el seguro por accidents de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañia de seguros, presenta información falsa o engañosa. El fraude del seguro por accidents de trabajo as un delito mayor de tercer grada que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta $25,000.00 se les puede pagar a personas quienes proven información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0455 para reporter sospechas de fraude de sequros por accidents de trabajo.

Certificado de elección para exenciones

Industrias dedicadas a la construcción

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

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

- Poseen un minimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que de testimonio a la propiedad del 10 por ciento minima.
- El official de la compañia aparece como official de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece active en el registro del Departamento del Estado de la Florida, División de Corporaciones.

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

Industrias que no se dedican a la construcción

Un empleado que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada complete o jornada parcial tiene que obtener la cobertura de sequros por accidents de trabajo.

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

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

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

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

Para consequir copias de la notificación de elección para ser exento (en Inglés Notice of Election to Be Exempt) llame al (850) 413-1609 o vaya a nuestro sitio Web en http://www.MyFloridaCFO.com/WC/forms.html, y haga clic en la regla 69L-6 y número del formulario DWC-250 Elección de ser exento.

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

- Provisión oportuna de tratamiento médico
- Provisión oportuna de beneficios de reemplazo de salario
- Pago opotuno de cuentas médicas
- Notificación oportuna de su reclamación a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamación. Esta información se le será proveida por correo en un formulario titulado "Notice of Action/Change" (DWC-4) [Notificación de Acción o Cambio (DWC-4)] "Notice of Denial" (DWC-12) [Notificación de Negación (DWC-12)].

¿Tiene preguntas sobre el seguro por accidents de trabajo?

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

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

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

Servicio al cliente (850) 413-1601

Empleadores pueden hacer preguntas por correo electrónico

WorkCompCustServ@MyFloridaCFO.com

Preguntas sobre el programa contra el fraude

1-800-378-0445

Preguntas hechas con frecuencia

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

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

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

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

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

R) Si. Usted debe reporter todas las demandas de lesions o de enfermedad relacionadas con el trabajo a su compañia de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesions u de las enfermedades. Es responsabilidad de la compañia de seguros por accidents de trabajo investigar todas las demandas y determiner si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidents de trabajo..

P) ¿El empleado paga parte de la prima de seguor por accidents de trabajo?

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

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

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

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

Limitación de responsabilidad

Esta publicación esta siendo ofrecida solo como una herramienta de información, acata s.440.185 (4) F.S., con el entendimiento que esto no es lenguaje official de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación or accidents de trabajo responsible de daños directos o resultants del uso de ese material.

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 39L-3.025, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010

IMPORTANT NOTICE – CONTACT INFORMATION – FLORIDA

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.

Please review your policy carefully. Should you have any questions concerning coverages, billings, additions or deletion, please contact your agent. Should you feel the need for additional information or wish to make a complaint, we offer the following number:

For information or to make a complaint, call
1-800-328-2189

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: UB-6N259033-22-14-G Effective Date of Policy: 02-15-22

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

1) Written safety policy and safety rules
2) Safety inspections
3) Preventive maintenance
4) Safety training
5) First aid
6) Accident investigation
7) Necessary record keeping

I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s.775.083 or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Certification of Employer Workplace Safety Program Premium Credit, and that the facts stated in it are true.

Employer Name	Date	Officer/Owner Signature*

Title

*Application must be signed by an officer or owner.

FLORIDA DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- ☐ Job applicant
- ☐ Reasonable suspicion
- ☐ Routine fitness for duty
- ☐ Follow-up testing to Employee Assistance Programs

Notice of Employer's Drug Testing Policy:

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

Education:

- ☐ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____

B. Phone No.: ( ) _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and that the facts stated in it are true.

_____	_____	_____
Employer Name	**Date**	**Officer/Owner Signature***

_____

Title

***Application must be signed by an officer or owner.**

NAMED INSURED: CHAMPLAIN COLLEGE INCORPORATED

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

EFFECTIVE DATE: 02-15-22

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF THE FLORIDA OVERSIZED POSTING NOTICES

W09P1 — (ENGLISH)

AND

W09P2 — (SPANISH)

ATTACH STICKERS THAT MATCH DATA BELOW:

EMPLOYER–Name:	CHAMPLAIN COLLEGE INCORPORATED
Address:	PO BOX 670
	BURLINGTON VT 05402
CARRIER–Name:	THE TRAVELERS INSURANCE COMPANIES
Address:	VARIES BY LOCATION
AGENT–Name:	HICKOK & BOARDMAN INS
POLICY NUMBER:	UB-6N259033-22-14-G

MANUAL INSERT REQUIRED

MANUAL INSERT REQUIRED

See instructions on other side.