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-HI**

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				
DEPARTMENT OF LABOR IDENTIFIER 0007531052				
CHAMPLAIN COLLEGE INCORPORATED				
HI- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**8779.00**	**0.71**	**62**

HI MANUAL PREMIUM $ 62

0.80% EMPL. LIAB. INCREASED LIMITS(9807)	**$ 0**
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	**62**
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM	**40**
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	**40**
-4.60% PREMIUM DISCOUNT(0064)	**-2**
TERRORISM(9740)	**1**
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	**1**
TOTAL ESTIMATED PREMIUM	**40**
TOTAL PREMIUM	**40**
DEPOSIT AMOUNT DUE	**40**

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 52 06 02 (13)

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

HAWAII NOTIFICATION ENDORSEMENT

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

Hawaii law requires that all policies issued to employers for workers compensation insurance disclose clearly to employers as separate figures the portion of the premium charged for categories (1) through (5) below. Category (6) is provided for informational purposes only so that the figures total 100% in Column A. These figures are provided below in column A as percentages of standard premium because rates are filed and approved on a standard premium basis. If the figures were not provided as percentages of standard premium, the percentages would vary by policy based on any premium discounts applied to the individual policy. Hawaii law also requires the disclosure of the percentages of premiums expended during the previous year by the insurer for claims paid in the same categories. These percentages are provided below in Column B based on the most recent available calendar year data. The figures in Column B may not total to 100% since premiums collected in any individual calendar year will not correspond exactly to the claims and expenses paid in that calendar year.

Category	A	B
(1) Medical care, services, and supplies	33.0%	190.0%
(2) Wage loss benefits including temporary total, temporary partial, and permanent total disability benefits and their related benefits	18.1%	104.1%
(3) Indemnity benefits for permanent partial disability	18.7%	107.7%
(4) Death benefits	0.3%	1.6%
(5) Loss control and administrative costs, attorney's fees of the insurer, the cost of employer requested medical examinations and private investigation costs	16.3%	31.7%
(6) Production costs, general expense, premium tax, Special Compensation Fund, miscellaneous tax, Hawaii Hurricane Relief Fund	13.7%	24.4%

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

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

NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR HAWAII WORKERS' COMPENSATION MEDICAL BENEFITS

Hawaii Policyholders

Hawaii law now permits an employer to buy Workers' Compensation Insurance with a deductible. This deductible is for medical benefits and applies separately to each bodily injury or accident or disease during the policy term, regardless of the number of employees who sustain injury in the accident. The deductible amount is subject to a minimum of $100 and a maximum of $10,000 for each accident, with intermediate increments shown in the table below.

To prevent putting you in an uninsured position, your policy has been issued at full rates with no deductible applied.

If you wish to have this deductible option apply to your policy, fill in the information requested at the bottom of this form. Retain your copy for your records and send the producer and company copies to your producer within sixty (60) days after the effective date of your policy. An endorsement (WC 52 06 01 (A)) will then be attached to your policy to reflect the change.

If you decide that you do not want the deductible to apply, or if you already have a deductible 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, please contact your producer.

DEDUCTIBLE TABLE

MEDICAL DEDUCTIBLE SELECTED BY HAWAII EMPLOYER:			
	$100	$750	$4,000
	$150	$1,000	$4,500
	$200	$1,500	$5,000
	$250	$2,000	$7,500
	$300	$2,500	$10,000
	$400	$3,000	
	$500	$3,500	

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

Yes, I want a deductible of $_____ applied as indicated above under the Hawaii Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that I have the option of modifying the above deductible program choice at the time of renewal of my Workers ' Compensation policy.

Date: _____

Employer: _____

Name: _____

Title: _____

Signature: _____

Insurance Company: _____

Producer Name: _____

Policy Number: _____ Producer/Company

State of Hawaii
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION

GUIDE FOR COMPLETING AND FILING INDUSTRIAL ACCIDENT REPORTS UNDER HAWAII'S WORKERS' COMPENSATION LAW

FOR EMPLOYERS AND INSURANCE CARRIERS

This guide was prepared by the Disability Compensation Division of the Department of Labor and Industrial Relations to assist employer and insurance carrier personnel responsible for industrial injury administration. It is designed primarily to assist personnel presently engaged in accident claims processing and to serve as the training aid when new personnel are hired to do this work.

REPORTS

A. EMPLOYEE'S REPORT OF INDUSTRIAL INJURY (WC-1)

The law provides that every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported and submitted within 7 working days to the Disability Compensation Division, hereinafter referred to as (DCD). The 7 working days limitation runs from the first day the employer has knowledge of the occurrence of the accident and for this purpose where supervisory personnel of the employer learn of the accident, the employer is deemed to have knowledge of the accident

The Employer's Report of Industrial Injury is the basic accident document and for this reason every applicable question and item must be answered accurately to avoid further effort on the part of the DCD and you. It should be borne in mind that further effort entails unnecessary additional work and creates greater processing costs for all concerned.

COMPLETING THE WC-1

Please do not write in the shaded blocks. These spaces are for Division use only for computer code entry.

1. IDENTIFICATION SECTION

Name of employee. Enter the employee's name correctly - last name first. In this respect, it would be advisable to enter the name as shown on the employee's social security identification card.

Employee's social security number. The employee's correct social security number is necessary and must be included.

Employee's date of birth. An employee's correct date of birth is an important identification factor, as well as being a benefits level determinant for injured workers who are under age 25.

Employee's sex and marital status. Place an (X) in the appropriate box.

Employee's address. Self-explanatory. The employee's home address should be used whenever possible rather than a post office box number. Any change of address following submission of WC-1 to the Disability Compensation Division should be communicated to the Division as soon as practicable. Any additional information should be entered in the appropriate box. City, State and zip code should be properly entered.

Employee's occupation. Enter the employee's occupation, i.e. carpenter, structural ironworker, heavy duty mechanic, auto mechanic, truck driver, laborer, sales clerk, bookkeeper, cashier, cable splicer, pressman, etc.

How long employed by you at this occupation? Self-explanatory.

Employee's department. Enter the name of the department to which employee was assigned at the time of injury or illness, whether or not employee was actually working in the department at the time. In the absence of formal department titles, enter a brief description of normal work place to which employee is assigned.

Employee's compensation class code. Enter the employee's rating manual occupation class code. This information is for the Hawaii Insurance Rating Bureau to assure proper payroll class designation for proper rating and premium determination.

Name of employer. Enter name of employer exactly as the employer's name appears on the workers' compensation insurance policy or as a self-insurer on the certificate of self-insurance.

Employer's address. Self-explanatory.

Nature of business. Enter the principal type of business activity engaged in, i.e. restaurant, service station, contracting, auto repair shop, etc.

Date injury or illness reported. Enter the date the employer was informed of the injury or illness. For this purpose, a foreman, supervisor, or any other management personnel is considered the employer.

Date of injury or illness. Self-explanatory.

DOL number. Enter the Department of Labor (DOL) account number which is the same as your Unemployment Insurance (UI) or Temporary Disability Insurance (TDI) account number.

2. DETAILS OF INJURY/ILLNESS

Time of injury/illness. Self explanatory.

Place of injury/illness if different from mailing address. Enter address or brief description of location where injury/illness occurred if different from premises or principal place of business previously designated as employer (mailing) address.

How did this accident occur. What was employee doing when injured. Object or substance that directly injured the employee. Self-explanatory. Should be sufficiently detailed to provide complete explanation or description.

Describe in detail the nature of the injury/illness and part of the body affected. Describe the injury fully clearly designating the affected part of the body, i.e. amputation of right arm, crushing injury to chest, lead poisoning, dermatitis of right arm and hand, etc.

3. TIME LOST INFORMATION

Date disability began. If the employee could not complete his workday because of the accident, enter here the date of the accident If the employee worked his scheduled hours on the day of the accident, then enter the date of the first day his disability started.

Was employee furnished meals or lodging? In the event the worker is furnished meals or lodging, enter yes and the market value of each.

Average weekly wage. Wage information on an employee is a very important and significant factor in a claim. A claimant's wage establishes the basis and the rate at which weekly compensation payments must be made if the employee is temporarily disabled for work or sustains a permanent disability from the accident, or in the case of death, dependency benefits.

Section 386-51 of the Workers' Compensation Law mandates the computation of average weekly wage in a manner that the result represents most fairly, in the light of a worker's employment pattern and duration of disability, his average weekly wage from all employment covered by the law at the time of the injury. Generally, it is a relatively simple calculation.

(a) Where an employee works a regular 40-hour workweek and

- **(1)** is employed only at a rate per hour, multiply the hourly rate by 40 and the result is the average weekly earnings.
- **(2)** is only on a pre-determined and fixed semi-monthly salary, multiply the semi-monthly salary by 24 (months) then divide by 52 (weeks) and the result is the average weekly earnings.
- **(3)** is only on a pre-determined and fixed monthly salary, multiply the monthly salary by 12 (months) then divide by 52 (weeks) and the result is the average weekly earnings. (A monthly salary multiplied by factor .2308 also yields the average weekly earnings.)

(b) Where an employee is injured in part-time employment the average weekly wage cannot be lower than that of an employee in comparable employment. In such a case, obtain the average weekly wage of an employee working on a full-time basis in the same occupation. It should be noted, however, that in the event there is no comparable employment, the average weekly wage cannot be less than the injured employee's hourly rate multiplied by 35 (hours).

(c) Where an employee is employed in more than one employment (i.e. full-time with one employer and part-time for another or part-time with both employers) his earnings from both jobs must be included in arriving at his average weekly wage. The employer in whose employment the injury occurred has to obtain the injured employee's earnings from the other employment. In such a case, indicate this under Item 12 or on the reverse of the form. If the employee is injured in the part-time employment, also refer to **(b)** above.

(d) Where an employee has had overtime earnings and/or bonuses which caused fluctuations in his earnings, take his total earnings for the twelve months preceding his injury and divide it by 52 weeks to get his average weekly earnings. If, however, because of sickness or other personal circumstances he did not work all of the 52 weeks, then use the number of weeks worked as a divisor instead of 52.

(e) Where an employee at the time of the injury was employed at a higher rate of pay than anytime during the twelve months preceding the injury, determine his average weekly earnings solely on the higher rate of pay.

Where an employee at the time of the injury was employed at higher wages than any other period of the preceding twelve months and had earned overtime pay during the twelve-month period, the average weekly overtime hours obtained by dividing the total overtime hours worked during the twelve-month period by 52 shall be multiplied by the overtime hourly rate based on the higher wages, and the product shall be added to the weekly straight time pay obtained by multiplying the straight time hourly rate based on the higher wages by the total number of straight time hours normally worked by the employee in a work week.

(f) Where an employee is under 25 years of age and sustains an injury causing permanent disability or death his average weekly wage shall be computed on the basis of the wages he would have earned in his employment had he been 25 years of age. In applying this provision of the law, the average weekly wage is determined as follows:

(1) Where the employee is employed in an occupation or job classification as an apprentice or trainee under the terms of an apprenticeship or on-the-job training program his average weekly wage shall be calculated on the basis of the rate of pay he would receive at age 25 under the apprenticeship or trainee agreement, plan, or contract. An apprenticeship or on-the-job training program is one which is registered with the Department of Labor and Industrial Relations, expressed in writing in a collective bargaining agreement or an employment contract, or one which the Director determines bears substantial similarities to that of an on-the-job or career training program based on a mutual employer-employee understanding.

(2) Where the employee is employed in an occupation or job classification and is not an apprentice or trainee, his average weekly wage shall be determined on the basis of the median rate of pay of the lowest and highest rate of pay of twenty-five year old employees employed in a similar occupation by his employer.

If there are no twenty-five year old employees in a similar occupation with the same employer, obtain the median rate of pay of twenty-five year olds in a similar occupation in employment with another employer in this State.

Whenever confronted with circumstances which this guideline does not provide adequate guidance, it is suggested that the Disability Compensation Division be contacted for assistance in determining the average weekly wage.

If employee is back to work, give date. Enter date employee returned to work.

If employee died, give date. If the injury resulted in death, give date employee died.

Give name and address of survivors on back. Names and addresses of surviving spouse, minor dependent children, and/or other survivors should be listed on back.

Hourly wage. If the employee is employed on an hourly basis, state the rate per hour.

Monthly salary. If the worker is on a fixed monthly salary, enter the amount of the salary.

Hours worked per week. Self-explanatory. Should include overtime hours.

4. TREATMENT

Name of physician - hospital. Self-explanatory.

5. INSURANCE

Name of workers' compensation insurance company. Enter the name of the insurance company as it appears on the insurance policy and if employer is a self-insurer, enter "self-insurer".

Name of general agency. If a general agent handles or administers the workers' compensation affairs for your insurance carrier, enter the full name of the agent. If an adjuster is administering or handling the workers' compensation affairs for the insurance carrier or the general agent, then also show the full name of the adjuster under this item.

If liability denied - why? Is liability denied? The usual order is reversed for date entry purposes. These questions are very important and must be entered. If liability is denied, mark "yes" and briefly state reason for denial.

MORE ON THE WC- 1

- The person submitting this report must be mindful that it has to be in the office of the DCD within 7 working days from the date the employer has knowledge of the accident.
- This report has to be retained by the DCD for a long time and in many cases up to 60 years, so it should be typed or completed in ink. The ORIGINAL and first copy shall be sent to the DCD if the accident occurred on Oahu. If the accident occurred on a neighbor island, the original and first two copies shall be sent to the appropriate district office of the Department of Labor and Industrial Relations.
- A copy of this report must be furnished to the injured employee.

B. CARRIER'S CASE REPORT (WC-3)

This form replaces previous forms WC-3a, Employer's Supplemental Report of Industrial Injury and WC-4, Employer's Final Report of Industrial Injury. The reporting requirements remain unchanged except that the WC-3, Carrier's Case Report, is to be used to report both supplemental and final payment information.

The completion and filing of the WC-3 as a supplemental report or as a final report is required by Section 386-95 of the Workers' Compensation Law. The supplemental report must be executed and submitted to the DCD no later than January 31 of each year on every accident case that is in "open status" on December 31 of each year. An "open status" case is one which up to December 31 of each year has not been closed by the submission of a Final Report, and the carrier or self-insurer has made payments on the case. Payments include any expenses on the case which the law requires.

A final report must be submitted after all payments on an industrial accident case have been completed. This means that all medical, hospital and other expenses have been paid and no further weekly or other compensation payments are due the claimant or dependents. The Workers' Compensation Law requires the submission of this report to the DCD within 30 days after final payment of compensation.

In addition a WC-3 must be submitted when: (1) payments are starting; (2) a case is reopened; (3) a hearing is requested; (4) a medical only case (often referred to as an open/close) is submitted, and (5) an adjustment or additional payment is made on an ended case.

Case number. Enter the DCD case number. This information should have been furnished you by the DCD following submission and processing of the WC-1.

Carrier case number. Enter here the insurance carrier or self-insurer case or file number.

Carrier I.D. This code or number to be entered by DCD. May be entered by insurance carrier or self-insurer if number known.

Claimants name and address. Enter the employee's name and address as it appears on the WC-1. If employee's address was changed subsequent to the submission of the WC-1, his current address should be shown and appropriately indicated as a change of address or current address.

Social security number. Enter employee's correct social security number as shown on the WC-1.

Date of injury/illness. Enter the date of injury or illness as shown on the WC-1.

Employer. Be sure to enter the employer's name as furnished initially on the WC-1.

Carrier name, address. Enter name of insurance carrier or self-insurer exactly as shown on WC-1. If claim is being handled by an insurance agency or an independent adjuster, it's name and address should appear under name of carrier.

Individual to contact. Please enter here the name of the insurance carrier, agent, adjuster, self-insured employer representative to whom inquiries regarding the WC-3, payment, and/or other claims information may be directed.

Telephone number. Enter the phone number of the representative to be contacted.

CHECK ONE. These spaces indicate the type of report being made. One and only one box should be checked.

1. **Date of first income replacement payment**. Check box and enter date first TTD payment made. Payment information should also be furnished.
2. **Reopen case.** Check box if case is being reopened because of recurring symptoms or additional medicals, etc.
3. **Hearing requested.** This box should be checked if a hearing is being requested.
4. **Medical only**. If the case involves medical payments only, and is, in effect, being opened and closed, then check this box and enter the date the payment was made, Also furnish numeric payment information in payment block. (Reminder: No report need be made unless the injury causes absence from work for one day or more or requires medical treatment beyond ordinary first aid.)
5. **Final payment to previously ended case.** This box should be checked when a final payment or adjustment is being made to amend or correct a payment error made in a previous ended case.
6. **Year end report.** Check this box to indicate that report is a supplemental or year end report. Be sure to indicate the payment year report is for, and include payment information in appropriate payment boxes.
7. **Final report** This box is to be checked if report is a final report. Enter all payment and expense information.

Return to work date. Enter date and submit report as soon as the date employee returned to work is known.

Payment block. Self explanatory. Amount blocks, disfigurement, medical other, and services of attendant must be numeric dollars and cents figures.

Carrier comments. Use this space to communicate with the DCD if you have a reason to do so, e.g. You may want to say that the claimant was discharged from further medical care, etc.

MORE ON THE WC-3.

- This report must be typed or completed in ink. If the accident occurred on Oahu, send the original of this report to DCD. If accident occurred on a neighbor island, then submit the original and first copy to the appropriate District Office of the Department of Labor and Industrial Relations.
- If report is a year end or final report, a copy of this report must be furnished to the injured employee.

DISABILITY COMPENSATION LAW

NOTICE TO EMPLOYEES

Workers' Compensation – You have the right to receive workers' compensation benefits and medical care if you suffer a work- related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance – You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling non-work-related injury/illness or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if a physician properly certifies your inability to work. Generally, you must have worked for an employer in Hawaii at least two weeks before your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care – You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The Department of Labor & Industrial Relations must approve the health care plan and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.

You should claim benefits under this program if a non-work-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu	586-9161 (Workers' Compensation)
	586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo	974-6464
Kona	322-4808
Maui	243-5322
Kauai	274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Anne E. Eustaquio, Director

Department of Labor and Industrial Relations

***You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster. For more information: http://labor.hawaii.gov/labor-law-poster/**

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
TDD/TTY Dial 711 then ask for (808) 586-8866.