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: THE TRAVELERS INDEMNITY COMPANY OF CONNECTICUT

INSURED'S NAME: CHAMPLAIN COLLEGE INCORPORATED **12637-KY**

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 KY- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	55213.00	0.26	144

KY MANUAL PREMIUM $ 144

0.80% EMPL. LIAB. INCREASED LIMITS(9807)	$ 1
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	145
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM	94
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	94
-4.60% PREMIUM DISCOUNT(0064)	-4
TERRORISM(9740)	4
CAT(OTHER THAN CERT ACTS OF TERRORISM)(9741)	9
TOTAL ESTIMATED PREMIUM	103
6.94% KY SPECIAL FUND ASSESSMENT	7
TOTAL PREMIUM	110
DEPOSIT AMOUNT DUE	110

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ENDORSEMENT WC 16 03 05 (00)

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

KENTUCKY PART ONE WORKERS COMPENSATION INSURANCE ENDORSEMENT

This endorsement modifies the insurance policy to which it is attached and applies to the insurance provided by this policy because Kentucky is shown in Item 3.A. of the Information Page.

F. 3. of Part One, Workers Compensation Insurance of the policy is replaced by the following:

F. Payments You Must Make

3. you fail to comply with a health or safety law or regulation; provided that, however, we are responsible for payment of any amounts in excess of the benefits regularly provided under the workers compensation law of this state if an accident is caused in any degree by the intentional failure of the employer to comply with any specific statute or lawful administrative regulation made thereunder, communicated to the employer and relative to the installation or maintenance of safety appliances or methods as provided in KRS 342.165(1); or

Except for any payments for which we are responsible as provided in Section F.3. above, if we make any payments in excess of the benefits regularly provided by the workers compensation law on your behalf, you will reimburse us promptly.

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:

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 06 01 (00)

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

KENTUCKY CANCELATION AND NONRENEWAL ENDORSEMENT

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

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

Cancelation

1. You may cancel this policy. You will deliver or mail advance written notice to us, stating when the cancelation is to take effect.
2. We may cancel this policy. We will deliver or mail to you not less than 75 days advance written notice stating when the cancelation is to take effect and our reason or reasons for cancelation. If we cancel for nonpayment of premium or within 60 days of the date of issuance of the policy, we will deliver or mail this notice not less than 14 days prior to the effective date of cancelation. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
3. After coverage has been in effect more than 60 days or after the effective date of a renewal policy, we may not cancel the policy unless cancelation is based on one or more of the following reasons:
   a. nonpayment of premium;
   b. discovery of fraud or material misrepresentation made by you or with your knowledge in obtaining the policy, continuing the policy, or presenting a claim under the policy;
   c. discovery of willful or reckless acts or omissions on your part increasing any hazard originally insured;
   d. changes in conditions after the effective date of the policy or any renewal substantially increasing any hazard originally insured;
   e. a violation of any local fire, health, safety, building, or construction regulation or ordinance at any of your covered workplaces substantially increasing any hazard originally insured;
   f. our involuntary loss of reinsurance for the policy;
   g. a determination by the commissioner that the continuation of the policy would place us in violation of Kentucky insurance laws.

Nonrenewal

1. We may elect not to renew the policy. We will deliver or mail to you not less than 75 days advance written notice stating our intention not to renew and our reason or reasons for nonrenewal. Proof of mailing of this notice to you at your mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.
2. If we fail to provide the notice of nonrenewal as required, the policy will be deemed to be renewed for the ensuing policy period upon payment of the appropriate premium, and coverage will continue until you have accepted replacement coverage with another insurer, until you have agreed to the nonrenewal, or until the policy is canceled.
3. If we have delivered or mailed to you a renewal notice, bill, certificate, or policy not less than 30 days before the end of the current policy period clearly stating the amount and due date of the renewal premium charge, then the policy will terminate on the due date without further notice unless the renewal premium is received by us or our agent on or before the due date. If the policy terminates in this manner, we will deliver or mail to you within 15 days of termination at your mailing address shown in Item 1 of the Information Page a notice that

the policy was not renewed and the date on which coverage ceased to exist. Proof of mailing of the renewal premium to us or our agent on or before the due date will constitute a presumption of receipt on or before the due date.

4. If we offer to renew the policy for a premium amount more than 25% greater than the premium amount for the current policy term for like coverage and like risks, we will deliver or mail to you and your agent not less than 75 days advance written notice of the renewal premium amount. We may at our option, in order to comply with this requirement, extend the period of coverage of the current policy at the expiring premium.

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WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 16 06 02 (00)

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

KENTUCKY NOTICE OF APPEAL RIGHTS ENDORSEMENT

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

NOTICE OF YOUR RIGHTS

If you believe that the rates or the rating system under this policy have been incorrectly or improperly applied, you may request a review of the manner in which the rate or rating system has been applied. You must make your request in writing to us or the National Council on Compensation Insurance, Inc. (NCCI). We or NCCI has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, we or NCCI shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of your review. Your appeal is to be sent to:

Legal Division
Department of Insurance
P. O. Box 517
Frankfort, KY 40602

Your request for an appeal should include a statement of the facts and how the rates or rating system were incorrectly or improperly applied. Also, enclose copies of the results of the review and any other correspondence from us or NCCI. If your appeal shows good cause, the commissioner shall hold a hearing. The commissioner may, after the hearing, issue a final order affirming, modifying or reversing our or NCCI's action.

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NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE FOR KENTUCKY WORKERS' COMPENSATION INDEMNITY AND MEDICAL BENEFITS

Kentucky Policyholders

Kentucky law now permits an employer to buy Workers' Compensation Insurance with a deductible. The deductible is for medical and indemnity benefits and applies separately to each bodily injury by 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 for medical benefits.

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 agent and company copies to your agent within sixty (60) days after the effective date of your policy. An endorsement (WC 00 06 03 (00)) 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 agent.

DEDUCTIBLE TABLE

INDEMNITY AND MEDICAL DEDUCTIBLE PER ACCIDENT:	$100	$200	$300	$400
	$500	$,1000	$1,500	$2,500
	$5,000	$7,500	$10,000	

Yes, I want a deductible of $_____ applied to my medical and indemnity benefits under the Kentucky Workers' Compensation Law. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Kentucky revised statutes, I have the option of modifying the above deductible 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: _____

Producer's Name: _____

Policy Number: _____

DATE OF ISSUE: 02-14-22

Important Notice Concerning Your Kentucky Workers Compensation Posting Notice

Dear Policyholder:

Enclosed is a new Posting Notice which must be posted in a conspicuous place where employees will readily see it. The State of Kentucky is requiring all insureds to specify whether they are participating in a Managed Care Plan for medical care. The State is also requiring the name of the Managed Care Plan, the representative, and the phone number. It is your responsibility to complete this required information. Contact your Company claim representative or the nearest claim office for assistance in completing this information. Refer to the Posting Notice for the address of the nearest claim office.

NOTICE OF INSURED'S RIGHTS

If you are insured under a workers' compensation insurance policy and believe that the rates or the rating system have been incorrectly or improperly applied, you may request a review of the manner in which the rate or rating system has been applied. You must make your request in writing to the insurance company or advisory organization. The insurance company or advisory organization has thirty (30) days to grant or reject your request for a review and to notify you in writing whether your request has been granted or rejected. If your request is granted, the insurance company or advisory organization shall conduct the review within ninety (90) days of receiving your request. If your request is rejected or if you are dissatisfied with the results of the review, you may appeal to the commissioner for further review. You must make your appeal within thirty (30) days of receipt of the rejection or of the results of the review. Your appeal is to be sent to:

Legal and Enforcement Division
Department of Insurance
P.O. Box 517
Frankfort, KY 40602

Your request for an appeal should include a statement of the facts and how the rates or rating system were incorrectly or improperly applied. Also, enclose copies of the results of the review and any other correspondence from the insurance company or advisor organization. If your appeal shows good cause, the Commissioner shall hold a hearing. The Commissioner may after the hearing issue a final order affirming, modifying, or reversing the action of the insurance company or advisory organization.

COMMONWEALTH OF KENTUCKY

WORKERS COMPENSATION NOTICE

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

Employer Name: CHAMPLAIN COLLEGE INCORPORATED

Address: PO BOX 670
BURLINGTON VT 05402

Workers Compensation Carrier
(or third party administrator): THE TRAVELERS INSURANCE COMPANIES

Policy #: UB-6N259033-22-14-G , effective 02-15-22 to 02-15-23

Address: P.O. BOX 4614
BUFFALO, NY 14240-4614

Telephone: (800) 238-6225 , Contact Person CLAIM MANAGER

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

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

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

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers compensation rights are not promptly answered call The Kentucky Department of Workers Claims at 1-800-554-8601 to speak to an Ombudsman or Workers Compensation Specialist.

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

W16P1P07