



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 CASUALTY AND SURETY COMPANY

INSURED'S NAME: CHAMPLAIN COLLEGE INCORPORATED

11223-ME

RATE BUREAU ID: 911451999

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

CLASSIFICATION	CODE	PREMIUM BASIS		ESTIMATED ANNUAL PREMIUM
		ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER \$100 OF REMUNERATION	
LOCATION 001 FEIN 030220266 ENTITY CD 001 00 STATE UNEMPLOYMENT IDENTIFIER 0251155003 CHAMPLAIN COLLEGE INCORPORATED				
ME- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	143134.00	0.42	601

ME MANUAL PREMIUM \$ 601

0.80% EMPL. LIAB. INCREASED LIMITS (9807)	\$	5
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.		606
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM		394
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		394
-4.60% PREMIUM DISCOUNT (0064)		-18
TERRORISM (9740)		10
CAT (OTHER THAN CERT ACTS OF TERRORISM) (9741)		20
TOTAL ESTIMATED PREMIUM		406
2.66% WC BOARD SURCHARGE		10
TOTAL PREMIUM		416
DEPOSIT AMOUNT DUE		416

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

**MAINE INSPECTION IMMUNITY ENDORSEMENT
(TITLE 14 MAINE REVISED STATUTES ANNOTATED SECTION 167)
THE FOLLOWING LIMITS OUR LIABILITY**

We, the insurance company, our agents, employees, or service contractors, are not liable for damages from injury, death or loss occurring as a result of any act or omission in the furnishing of or the failure to furnish insurance inspection services related to, in connection with or incidental to the issuance or renewal of a policy of property or casualty insurance.

This exemption from liability does not apply:

- A.** If the injury, loss or death occurred during the actual performance of inspection services and was proximately caused by our negligence or by the negligence of our agents, employees or service contractors;
- B.** To any inspection services required to be performed under the provisions of a written service contract or defined loss prevention program;
- C.** In any action against us, our agents, employees, or service contractors for damages proximately caused by our acts or omissions which are determined to constitute a crime, actual malice or gross negligence; or
- D.** If we fail to provide this written notice to the insured whenever a policy is issued or when new policy forms are issued upon renewal.

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MAINE CANCELATION AND NONRENEWAL ENDORSEMENT

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

The Cancellation Condition of the policy is replaced by this Condition:

Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We must mail or deliver to you and to the Workers Compensation Board not less than 30 days advance written notice stating when the cancellation is to take effect. Mailing notice to you at your last known address will be sufficient to prove notice.
3. The policy period will end on the day and hour stated in the cancellation notice. If you have obtained a workers compensation and employers liability insurance policy from another insurance company, or have otherwise secured your obligation to provide compensation, and such insurance or other security becomes effective prior to the expiration of the notice period, the policy period will end on the effective date of such other insurance or security.
4. If this policy has been renewed or has been in effect for 60 days or more, we may cancel only for one of the following reasons:
 - a. Nonpayment of premium;
 - b. Fraud or a material misrepresentation was made in obtaining the policy, continuing the policy or presenting a claim under the policy.
 - c. The risk accepted when the policy was issued has substantially increased;
 - d. Your failure to comply with reasonable loss control recommendations;
 - e. A substantial breach of contractual duties, conditions or warranties under the policy;
 - f. The Superintendent has determined that continuation of the policy could jeopardize our solvency or place us in violation of the law.

Nonrenewal

We may elect not to renew the policy. We will mail or deliver to you not less than 30 days advance written notice. A post office certificate of mailing to you at your last known address will be conclusive proof of receipt of that notice on the third calendar day after mailing.

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

MAINE FINAL PREMIUM AUDIT ENDORSEMENT

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

Part Five (Premium), Condition E, Final Premium, and Condition G, Audit, are changed by adding these conditions:

E. Final Premium

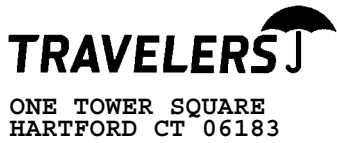
We are required by Maine regulation to complete our final premium audit no later than 120 days after the policy period ends.

If we are unable to examine and audit your records because of your failure to cooperate, we will mail advance written notice to you stating the reasons for our inability to establish the final premium. Your final premium will be established no later than 120 days from the time we are able to complete the examination and audit of your records.

If we have not established the final premium within the 120-day time limitation, we may not bill or collect any additional premium that exceeds the latest billed annual premium.

G. Audit

You may request a final premium audit to determine whether you are entitled to a refund, if we have not established the final premium within the 120-day time limit. You may mail or deliver written notice to us requesting the audit.



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY
ENDORSEMENT WC 18 06 06 (00)**

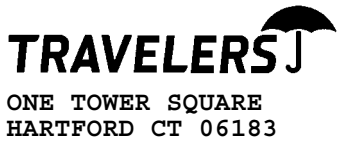
POLICY NUMBER: UB-6N259033-22-14-G

**MAINE NOTICE OF FILING OF FIRST REPORTS OF INJURY
WITHIN SEVEN DAYS ENDORSEMENT**

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

Employer's First Report of Occupational Injury or Disease, form WCB-1, required to be filed for injuries arising out of and in the course of an employee's employment that has caused the employee to lose a day's work shall be reported to and received by the Workers' Compensation Board within seven (7) days after the employer receives notice or knowledge of the injury, as provided by 39-A M.R.S.A. sec. 303. First Reports of Injury can be mailed, electronically submitted or faxed to the Workers' Compensation Board at 207-287-5895.

Contact us immediately if an injury occurs which may be required to be reported to the Workers' Compensation Board.



WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 18 06 07 (A)

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

MAINE EMPLOYMENT REHABILITATION FUND ENDORSEMENT

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

We are required by the Maine Employment Rehabilitation Fund, to collect a surcharge for this policy to fund payments made in accordance with the reimbursement provisions of Section 355 of Title 39A. Assessments may be levied during this policy period if exigent conditions arise and the balance in the fund is inadequate to discharge reimbursement in a timely fashion.

Schedule

See Schedule page for Surcharge.

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 Insured

Policy No.

Endorsement No. Premium \$

Insurance Company

Countersigned by _____

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

**NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE
 FOR MAINE WORKERS' COMPENSATION INDEMNITY BENEFITS
 OR MEDICAL EXPENSE ONLY BENEFITS**

Maine Policyholders

Maine law now permits an employer to buy Workers' Compensation Insurance with a deductible. One deductible is for indemnity 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 of \$1,000 and a maximum of \$5,000 for each accident. The other deductible is for medical expense only and also 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 either \$250 or \$500 for each accident or per occurrence (See 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 a 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 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.

<u>INDEMNITY BENEFITS DEDUCTIBLE PER ACCIDENT</u>	<u>MEDICAL BENEFITS DEDUCTIBLE**</u>
\$1,000	\$250
\$5,000	\$500

**The Medical Benefits Deductible option is available as follows: \$250 to employers who are not Experienced Rated, insurers shall offer a deductible of \$250 per accident for bodily injury or disease regardless of the number of people who sustain injury by such accident or disease. \$250 or \$500 to employers who are Experience Rated, insurers shall offer a deductible of \$250 or \$500 per occurrence.

Yes, I want a deductible of \$ _____ Indemnity Benefits and/or a deductible of \$ _____ Medical expense applied. I understand that the company shall pay the deductible amount and seek reimbursement from the employer shown below.

I understand that in accordance with Maine Laws, 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: _____

Insurance Company: _____

DATE OF ISSUE: 02-14-22

NAMED INSURED: CHAMPLAIN COLLEGE INCORPORATED

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

EFFECTIVE DATE: 02-15-22

GUNTHER OPERATOR:

MANUALLY INSERT 1 COPIES OF W18P1

MAINE OVERSIZED POSTING NOTICES

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