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-MA**

RATE BUREAU ID: 911451999

EXP. MOD. EFFECTIVE DATE: 02-15-22 **MA BUREAU FILE NO: 911451999**

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				
MA- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	**8868**	**102290.00**	**0.64**	**655**

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MA MANUAL PREMIUM $ 655

1.00% EMPL. LIAB. INCREASED LIMITS(9807)	$ 7
TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	662
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM	430
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM	430
0% ARAP MODIFICATION PROGRAM(0277)	0
-8.20% PREMIUM DISCOUNT(0063)	-35
0% LOSS CONSTANT(0032)	20
EXPENSE CONSTANT(0900)	250
TERRORISM(9740)	31
TOTAL ESTIMATED PREMIUM	696
4.18% DIA ASSESSMENT	18
TOTAL PREMIUM	714
DEPOSIT AMOUNT DUE	714

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 03 01 (00)

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

MASSACHUSETTS LIMITS OF LIABILITY ENDORSEMENT

This endorsement applies only to the insurance provided by Part Two (Employers Liability Insurance) because Massachusetts is listed in item 3.A of the Information Page.

Our liability to you under Section 25 of Chapter 152 of the General Laws of Massachusetts is not subject to the limit of liability that applies to Part Two (Employers Liability Insurance).

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

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 03 02 (A)

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

MASSACHUSETTS – ASSESSMENT CHARGE

Massachusetts General Laws, Chapter 152, Section 65, as amended by Chapter 572 of the Acts of 1985, establishes a workers compensation special fund and a workers compensation trust fund.

On behalf of the Department of Industrial Accidents (DIA), the insurance company providing workers compensation coverage is required to bill and collect an assessment charge covering the special and trust funds from insured employers and remit the amounts collected to the State Treasury.

The assessment charge, which is determined by applying a rate (subject to annual change) to the **DIA's** standard premium, **as defined and outlined in 452 CMR 7.00**, developed under your policy, is shown as a separate item on the information page of the policy. The rate may be different for private employers and for the Commonwealth and its political subdivisions.

The income derived from the assessment charge will be used to fund the operating expenses of the DIA and to fund certain employee benefits as described in Chapter 152.

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 20 03 03 (D)

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

MASSACHUSETTS NOTICE TO POLICYHOLDER ENDORSEMENT

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

1. Rates and Premium

The policy contains rates and classifications that apply to your type of business. If you have any questions regarding the rates or classifications, please contact your agent or us.

You may obtain pertinent rating information by submitting a written request to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this endorsement or to us at our company address shown on this endorsement. We may require you to pay a reasonable charge for furnishing the information.

You may also submit a written request for a review of the method by which your classification, rates, premiums or audit results were determined. If we fail to grant or reject your request within thirty days after it is made or if you are not satisfied by the results of our review, you may submit a written request for review to the Workers' Compensation Rating and Inspection Bureau of Massachusetts ("WCRIBMA") at the address shown in this endorsement. If the WCRIBMA fails to grant or reject your request within thirty days after it is made or if you are not satisfied with the results of the WCRIBMA review, you may appeal to the Commissioner of Insurance at the address shown in this endorsement.

2. Reserve or Settlements

You may request a loss run, which contains reserve and settlement information for claims that relate to the premium for this policy. Such a request must be in writing and should be sent to our address shown on this endorsement. We will provide you with that information within thirty (30) days of receipt of your request, and at reasonable intervals thereafter.

If you have any questions or believe that we set unreasonable reserves or made unreasonable settlements that affected your premiums or losses, you may make a written request through your agent or directly to us for a meeting with our company representative. If you are not satisfied with the results of the meeting, you may make a written appeal to the Insurance Commissioner at the address shown on the endorsement.

3. Named Insured

You are responsible for immediately reporting all changes in name or legal status to us in writing at the company address shown in this Endorsement.

If you want to add a named insured or replace the named insured with another legal entity on any policy issued through the Massachusetts Assigned Risk Pool you must submit a new Assigned Risk Pool Application, including a Confidential Request for Information Form (ERM), to the Workers' Compensation Rating and Inspection Bureau of Massachusetts at the address shown in this Endorsement

4. Insured's Mailing Address

Notices relating to this Policy will be mailed or delivered to your mailing address. Your mailing address is that which is shown in Item 1 of the Information Page or in a change of address Endorsement to the Policy. You are responsible for notifying us in writing at the company address shown in this Endorsement about any change to your mailing address.

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 03 03 (D)

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

Addresses

The Workers' Compensation Rating and
Inspection Bureau of Massachusetts
Attention: Customer Service Department
101 Arch Street, 5th Floor
Boston, MA 02110
www.wcribma.org

Commissioner of Insurance
Division of Insurance
Department of Banking and Insurance
1000 Washington St 8th Floor
Boston, MA 02118-2218

Address Correspondence as follows:

Policies with a 6NUB or 7UB in their symbol, to:
Travelers Insurance Company
P.O. Box 3556
Orlando, Florida 32802-3556

Policies with a 6S59UB in their symbol, to:
Direct Assignment Operations
P.O. Box 4965
Orlando, Florida 32802-4965

Policy with a 6ZZUB in their symbol, to:
Direct Assignment Operation
P.O. Box 4964
Orlando, Florida 32802-4964

Policy with a 6S6OUB in their symbol, to:
Direct Assignment Operation
P.O. Box 4903
Orlando, Florida 32802-4903

ALL OTHER POLICIES, TO:
The Travelers Insurance Company
P.O. Box 9203
Westwood, MA 02090-9203

TRAVELERS

ONE TOWER SQUARE
HARTFORD CT 06183

WORKERS COMPENSATION AND EMPLOYERS LIABILITY POLICY

ENDORSEMENT WC 20 04 05 (00)

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

MASSACHUSETTS PREMIUM DUE DATE ENDORSEMENT

Section D of Part Five of the Policy is replaced by this provision:

PART FIVE

PREMIUM

D. Premium Payments is amended to read:

You will pay all premium when due. You will pay the premium even if part or all of a workers compensation law is not valid. **The audit and retrospective premiums shall be paid by the due date indicated on the billing statement.**

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

ENDORSEMENT WC 20 06 01 (A)

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

MASSACHUSETTS CANCELLATION ENDORSEMENT

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

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

Cancellation

1. You may cancel this policy by mailing or delivering to us advance written notice requesting cancellation. Such cancellation shall not be effective until ten days after written notice is given by us to The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

2. We may cancel this policy only if based on one or more of the following reasons: (i) nonpayment of premium; (ii) fraud or material misrepresentation affecting your policy; or (iii) a substantial increase in the hazard insured against. Such cancellation shall not be effective until ten days after written notice is given by us to you and The Workers' Compensation Rating and Inspection Bureau of Massachusetts (Bureau), or until notice has been received by the Bureau that you have secured insurance from another insurance company, whichever occurs first. Our notice to the Bureau may be given by electronic transmission.

3. We will mail or deliver the notice of cancellation to you at your last address, which shall be the mailing address shown in Item 1 of the Information Page or the change of mailing address shown in an Endorsement to the Policy. Pursuant to M.G.L. Chapter 175, Section 187C, a written notice of cancellation shall be deemed effective when mailed by us if we obtain a certificate of mailing receipt from the United States Postal Service showing your name and address as stated in the policy.

4. Any of these provisions that conflict with the law that controls the cancellation of this insurance policy is changed by this statement to comply with the law.

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 _____

MASSACHUSSETTS
BENEFITS DEDUCTIBLE PROGRAM
BENEFITS CLAIM AND AGGREGATE DEDUCTIBLE PROGRAM

Dear Policyholder:

Section 25A of Chapter 152 Massachusetts Workers' Compensation Law requires the Massachusetts Workers' Compensation Assigned Risk Pool and voluntary market insurers to offer to insureds with workers' compensation policies, which provide coverage in Massachusetts, a choice of medical and indemnity benefits deductibles.

In accordance with the statute, as amended, the Division of Insurance has approved two separate and distinct deductible programs, one without an aggregate limit, and one with an aggregate limit. An insured may select either program, or neither of them. These programs are not available for insureds with retrospectively rated policies.

The first program, Massachusetts Benefits Deductible Program, without an aggregate limit, which has been in effect since January 1, 1993, is intended for insureds who have the financial ability to handle some losses they incur. This program allows these insureds to establish an amount of loss they can absorb and purchase insurance only for losses above that predetermined deductible amount.

Under this program, medical and indemnity deductibles of $500, $1,000, $2,000 and $2,500 shall be offered to every employer. In addition, an insurer or the Pool, at its option, may offer to any employer providing collateral deemed adequate by such insurer, a medical and indemnity benefits deductible of $5,000.

The deductible shall apply separately to each claim for bodily injury by disease or accident. The insurer shall pay all benefits required under the provisions of M.G.L.c.152 directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the deductible limit on any claim, the insurer may seek reimbursement from the policyholder. Failure to make complete reimbursement for deductibles within thirty days of receipt of bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect the Massachusetts Benefits Deductible Program, you must make your election before the effective date of your next policy.

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The second program, Massachusetts Benefits Claim and Aggregate Deductible Program, is intended for insureds who have the financial ability to handle some losses they incur, subject to an aggregate amount. This program will allow these insureds to elect an amount of loss per claim and an overall aggregate amount of all losses they can absorb and purchase insurance only for losses above those predetermined amounts. The amount of premium credit will vary by size of risk.

A medical and indemnity claim deductible of $2,500 and aggregate deductible amount of $10,000 shall be offered to every employer with a basis for the aggregate limit at policy inception not in excess of $200,000. Every employer with a basis for the aggregate limit of $200,000 and greater shall be offered a medical and indemnity claim deductible of $2,500 and an aggregate deductible amount of 5% of basis for the aggregate limit. The Aggregate Deductible amount and corresponding Premium Reduction Credit may change according to the level of final premium calculated at time of audit. The $2,500 claim deductible amount shall apply separately to each claim for bodily injury by accident or disease, subject to the aggregate deductible amount. The insurer shall pay all benefits required under the provisions of law directly to the appropriate party. Subsequent to insurer payment of any amount which falls within the $2,500 deductible limit on any claim, the insurer shall seek reimbursement from the policyholder. The aggregate deductible amount is the most that the policyholder must reimburse the insurer for the sum of all medical and indemnity benefits compensable under law for each policy period. Failure to make complete reimbursement for deductibles within 30 days of receipt of a bill from the insurer shall constitute non-payment of premium and be grounds for termination of the policy.

The entire cost of all claims shall be included in the experience data used to determine the experience modification of the insured regardless of the requirement that reimbursement must be made for the deductible amount on any claim.

If you wish to elect the Massachusetts Benefits Claim and Aggregate Deductible Program, you must make your election before the effective date of your policy.

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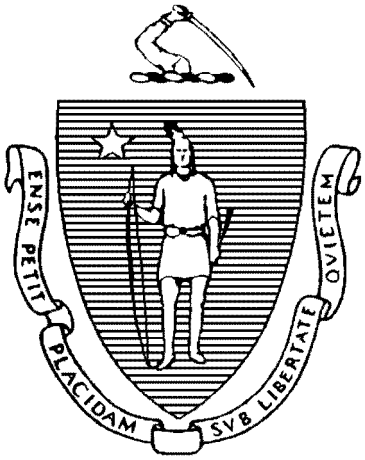
Please contact your producer or insurance company representative promptly for additional information, including the premium credit amounts which apply under these programs.

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts
DEPARTMENT OF INDUSTRIAL ACCIDENTS
LAFAYETTE CITY CENTER, 2 AVENUE DE LAFAYETTE, BOSTON, MA 02111
(617) 727-4900 – www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above mentioned chapter by insuring with:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

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

ADDRESS OF INSURANCE COMPANY

UB-6N259033-22-14-G **02-15-22** TO **02-15-23**

POLICY NUMBER EFFECTIVE DATES

HICKOK & BOARDMAN INS **PO BOX 1064**
BURLINGTON, VT 05402-1064

NAME OF INSURANCE AGENT ADDRESS PHONE #

CHAMPLAIN COLLEGE INCORPORATED **NO BUSINESS LOCATION**
MA

EMPLOYER ADDRESS

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

W20P1G15