



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-MN

RATE BUREAU ID: 911451999

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

| CLASSIFICATION                                | CODE | PREMIUM BASIS                             | RATES                        | ESTIMATED         |
|---|------|---|------------------------------|-------------------|
|   |      | ESTIMATED<br>TOTAL ANNUAL<br>REMUNERATION | PER \$100 OF<br>REMUNERATION | ANNUAL<br>PREMIUM |
| LOCATION 001                                  |      |   |                              |                   |
| FEIN 030220266 ENTITY CD 001 00               |      |   |                              |                   |
| STATE UNEMPLOYMENT IDENTIFIER 000002785250    |      |   |                              |                   |
| CHAMPLAIN COLLEGE<br>INCORPORATED             |      |   |                              |                   |
| MN- NO BUSINESS LOCATION                      |      |   |                              |                   |
| COLLEGE: PROFESSIONAL<br>EMPLOYEES & CLERICAL | 8868 | 52139.00                                  | 0.52                         | 271               |

MN MANUAL PREMIUM \$ 271

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|   |    |     |
|---|----|-----|
| 0.80% EMPL. LIAB. INCREASED LIMITS(9807)      | \$ | 2   |
| TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.      |    | 273 |
| EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM |    | 177 |
| TOTAL ESTIMATED ANNUAL STANDARD PREMIUM       |    | 177 |
| -4.60% PREMIUM DISCOUNT(0064)                 |    | -8  |
| TERRORISM(9740)                               |    | 5   |
| TOTAL ESTIMATED PREMIUM                       |    | 174 |
| 2.94% SPECIAL FUND SURCHARGE                  |    | 5   |
| TOTAL PREMIUM                                 |    | 179 |
| DEPOSIT AMOUNT DUE                            |    | 179 |



ONE TOWER SQUARE  
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**WORKERS COMPENSATION  
AND  
EMPLOYERS LIABILITY POLICY  
ENDORSEMENT WC 22 00 00 ( A)**

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

## **MINNESOTA AMENDATORY ENDORSEMENT**

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

### **PART TWO—EMPLOYERS LIABILITY INSURANCE**

**E. We Will Also Pay** is amended to read:

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding, or suit we defend:

1. Reasonable expenses incurred at our request, but not loss of earnings;
2. Premiums for bonds to release attachments and for appeal bonds in bond amounts up to the limit of our liability under this insurance;
3. Litigation costs taxed against you;
4. Your share of pre- or postjudgment interest assuming that the principal amount of that judgment is within the applicable policy limits under this insurance; and
5. Expenses we incur.

**H. Recovery From Others** is amended to read:

Our ability to exercise your rights to recover our payment from anyone liable for injury covered by this insurance does not apply if that other person is insured for the same loss by us. This limitation applies only if the loss was caused by the nonintentional acts of the person against whom subrogation is sought.

### **PART FIVE—PREMIUM**

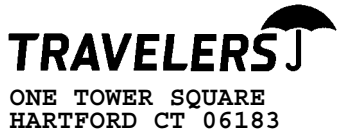
**G. Audit** is amended to read:

You will let us examine and audit all your records that relate to this policy. These records include ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data.

We may conduct the audits during regular business hours during the policy period and within three years after the policy period ends, except as it pertains to Part Two—Employer's Liability Insurance which shall be one year. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

### **DEFINITIONS**

As used in this policy, "rate service organization" shall mean the Minnesota Workers' Compensation Insurers Association, Inc.



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ENDORSEMENT WC 22 03 01 (00)

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

**MINNESOTA COMPLIANCE WITH APPLICABLE TRADE SANCTION LAWS**

This endorsement changes the policy to which it is attached effective on the inception of the policy unless a different date is indicated below.

This endorsement, effective on \_\_\_\_\_ at 12:01 a.m. standard time, forms a part of  
Policy No. \_\_\_\_\_ of the \_\_\_\_\_  
(Name of Insurance Company)

Issued to: \_\_\_\_\_

Endorsement No. \_\_\_\_\_  
Authorized Representative

Under Part Six – Conditions, the following condition is added:

This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

All other terms and conditions remain unchanged.

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

## **MINNESOTA CANCELLATION AND NONRENEWAL ENDORSEMENT**

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

### **Cancellation of a New Policy**

If this policy is a new policy and has been in effect for fewer than 90 days, we may cancel for any reason by giving you notice at least 60 days before the effective date of Cancellation.

### **Cancellation of Other Policies**

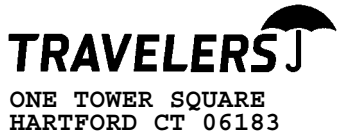
If this policy has been in effect for 90 days or more, or if it is a renewal of a policy we issued, we may cancel **for one or more** of the following reasons:

1. Nonpayment of premium;
2. Misrepresentation or fraud made by you or with your knowledge in obtaining the policy or in pursuing a claim under the policy;
3. An act or omission by you that substantially increases or changes the risk insured;
4. Refusal by you to eliminate known conditions that increase the potential for loss after notification by us that the condition must be removed;
5. Substantial change in the risk assumed, except to the extent that we should reasonably have foreseen the change or contemplated the risk in writing this policy;
6. Loss of reinsurance by us which provided coverage to us for a significant amount of the underlying risk insured. Any notice of cancellation pursuant to this item shall advise you that you have 10 days from the date of receipt of the notice to appeal the cancellation to the commissioner of commerce and that the commissioner will render a decision as to whether the cancellation is justified because of the loss of reinsurance within 30 business days after receipt of the appeal;
7. A determination by the commissioner that the continuation of the policy could place us in violation of the Minnesota insurance laws; or
8. Nonpayment of dues to an association or organization, other than an insurance association or organization, where payment of dues is a prerequisite to your obtaining or continuing this policy. This item shall not apply to persons who are retired at 62 years of age or older or who are disabled according to Social Security standards.

If we cancel your policy for any of the reasons listed in (2) through (8), we will give notice at least 60 days before the effective date of cancellation.

### **Notice of Cancellation**

Any notice of cancellation under this endorsement shall be in writing and shall be sent by first class mail or delivered to you and any agent, to the last mailing addresses known to us. A cancellation notice for nonpayment of premium must be sent at least 30 days before the actual date of cancellation and shall state the amount of premium due and the due date, and shall state the effect of nonpayment by the due date. Cancellation shall not be effective if payment of the amount due is made prior to the effective date of cancellation in the notice. A cancellation notice for some other reason shall state the specific reason for cancellation and shall state the effective date of cancellation. The policy will end on that date.



WORKERS COMPENSATION
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ENDORSEMENT WC 22 06 01 ( D)

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

Refunds Due You

If this policy is canceled, we will send you any premium refund due. If we cancel, the refund will be pro rata. If you cancel, the refund may be less than pro rata. The cancellation will be effective even if we have not made or offered a refund.

Nonrenewal of Your Policy

Any notice of nonrenewal shall be in writing and shall be sent by first class mail, or delivered to you and any agent, to the last mailing addresses known to us, at least 60 days before the expiration date.

We need not mail or deliver this nonrenewal notice if you have:

- 1. Insured elsewhere;
2. Accepted replacement coverage; or
3. Requested or agreed not to renew this policy.

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

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 \_\_\_\_\_

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

**NOTICE OF ELECTION TO ACCEPT AN INSURANCE DEDUCTIBLE  
 FOR MINNESOTAWORKERS' COMPENSATION MEDICAL AND INDEMNITY BENEFITS**

Minnesota Policyholders

Minnesota 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 \$50,000 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 00 06 03 (00)) will be then attached to your policy to reflect the change.

If you decide that you do not want a deductible to apply, 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**

| <u>MEDICAL DEDUCTIBLE</u> | <u>TOTAL CLAIM DEDUCTIBLE</u> |
|---------------------------|-------------------------------|
| \$100                     | \$100                         |
| \$150                     | \$150                         |
| \$200                     | \$200                         |
| \$250                     | \$250                         |
| \$500                     | \$500                         |
| \$1,000                   | \$1,000                       |
| \$1,500                   | \$1,500                       |
| \$2,000                   | \$2,000                       |
| \$2,500                   | \$2,500                       |
| \$5,000                   | \$5,000                       |
| \$10,000                  | \$10,000                      |
| \$25,000                  | \$25,000                      |
| \$50,000                  | \$50,000                      |

Yes, I want a: – **Medical Deductible** \_\_\_\_\_ **or** **Total Claim Deductible** \_\_\_\_\_

Yes, I want a deductible of \$ \_\_\_\_\_ applied to my medical and indemnity benefits under the Minnesota 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 Minnesota 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 OF ISSUE: 02-14-22

Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Agent's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

# Workers' compensation

## If you are injured

- Report any injury to your supervisor as soon as possible, no matter how minor it may appear. You may lose the right to workers' compensation benefits if you do not make a timely report of the injury to your employer. The time limit may be as short as 14 days.
- Provide your employer with as much information as possible about your injury.
- Get any necessary medical treatment as soon as possible. If you are not covered by a certified managed care organization (CMCO), you may treat with a doctor of your choice. Your employer must notify you in writing if you are covered by a CMCO.
- Cooperate with all requests for information concerning your claim.  
The law allows the workers' compensation insurer to obtain medical information related to your work injury without your authorization, but they must send you written notification when they request the information.  
The insurer cannot obtain other medical records unless you sign a written authorization.
- Get written confirmation from your doctor about any authorization to be off work. The note should be as specific as possible.

## Workers' compensation pays for

- Medical care for your work injury, as long as it is reasonable and necessary.
- Wage-loss benefits for part of your lost income.
- Compensation for permanent damage to or loss of function of a body part.
- Vocational rehabilitation services if you cannot return to your pre-injury job or to your pre-injury employer due to your work injury.
- Benefits to your spouse and/or dependents if you die as a result of a work injury.

## What the insurer must do

- The insurer must investigate your claim promptly. If you have been disabled for more than three calendar-days, the insurer must begin payment of benefits or send you a denial of liability within 14 days after your employer knew you were off work or had lost wages because of your claimed injury.
- **If the insurer accepts your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will notify you and must start paying wage-loss benefits within the 14 days noted above. The insurer must pay benefits on time. Wage-loss benefits are paid at the same intervals as your work paychecks.
- **If the insurer denies your claim for wage-loss benefits and you have been disabled for more than three calendar-days:** The insurer will send notice to you within 14 days. The notice must clearly explain the facts and reasons why they believe your injury or illness did not result from your work or why the claimed wage-loss benefits are not related to your injury.  
If you disagree with the denial, talk with the insurance claims adjuster who is handling your claim. If you are not satisfied and still disagree with the denial, **call the Minnesota Department of Labor and Industry's Workers' Compensation Hotline at 1-800-342-5354.**

### Fraud

Collecting workers' compensation benefits you are not entitled to is theft. Call 1-888-372-8366 to report workers' compensation fraud.

### Insurer name and contact information

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225



(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Posting required by law in a location where employees can easily see this notice.

August 2017



# Compensación laboral

## Si usted se lesiona

- Informe cualquier lesión a su supervisor tan pronto le sea posible; no importa qué tan leve le pueda parecer. Usted podría perder el derecho a los beneficios de compensación laboral si no presenta a tiempo un informe de la lesión a su empleador. El tiempo límite puede ser tan corto como 14 días.
- Provea a su empleador la mayor cantidad de información posible sobre su lesión.
- Obtenga el tratamiento médico que necesite lo más pronto posible. Si no está cubierto por una organización de atención médica certificada, (CMCO), usted puede recibir tratamiento con el doctor que usted elija. Su empleador debe notificarle por escrito si tiene cobertura con un CMCO.
- Colabore con todas las solicitudes de información relacionadas con su reclamo.  
La ley permite que la aseguradora de compensación laboral obtenga la información médica relacionada con su lesión sin su autorización, pero le debe enviar una notificación por escrito cuando solicite la información.  
La compañía aseguradora no puede obtener otros expedientes médicos a menos que usted firme una autorización por escrito.
- Obtenga una confirmación por escrito de su médico sobre cualquier autorización para ausentarse del trabajo. La nota debe ser lo más específica posible.

## Compensación laboral paga por lo siguiente

- Atención médica para su lesión ocurrida en el trabajo, siempre que sea razonable y necesaria.
- Beneficios por salario perdido para cubrir parte de los ingresos no recibidos.
- Compensación por daños permanentes o por pérdida de la función de una parte del cuerpo.
- Servicios de rehabilitación vocacional si usted no puede regresar al trabajo o a su empleador previo al accidente debido a su lesión en el trabajo.
- Beneficios para su cónyuge o dependientes si usted fallece como consecuencia de una lesión laboral

## Lo que la aseguradora debe hacer

- La compañía aseguradora deberá investigar su reclamo con prontitud. Si usted ha estado incapacitado por más de tres días calendario, la aseguradora debe iniciar el pago de beneficios o enviarle un aviso de negación de responsabilidades dentro de los 14 días después que su empleador se enteró de su ausencia laboral o había perdido parte de su salario debido a su reclamo por lesión.
- **Si la compañía aseguradora acepta su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le notificará y deberá iniciar el pago de los beneficios por pérdida de salario dentro de los 14 días mencionados anteriormente. La aseguradora deberá pagar los beneficios puntualmente. Los beneficios por pérdida de salario se pagan en los mismos intervalos que sus cheques de nómina.
- **Si la compañía aseguradora deniega su reclamo de beneficios por pérdida de salario y usted ha estado incapacitado por más de tres días calendario:** La aseguradora le enviará una notificación dentro de los 14 días. La notificación debe explicar claramente los hechos y motivos por los cuales ellos consideran que su lesión o enfermedad no fue resultado de su trabajo o por qué los beneficios por pérdida de salarios que reclama no están relacionados con su lesión.  
Si usted no está de acuerdo con la denegación, hable con el ajustador de reclamos de la aseguradora a cargo de su reclamo. Si usted no está satisfecho y aún está en desacuerdo con la denegación, **comuníquese con el teléfono gratuito para Compensación para Trabajadores del Departamento de Trabajo e Industria de Minnesota (Minnesota Department of Labor and Industry) al 1-800-342-5354.**

## Fraude

Cobrar beneficios de compensación laboral a los cuales no tiene derecho, se considera robo. Llame al 1-888-FRAUD MN (1-888-372-8366) para reportar fraude de compensación laboral.

## Nombre e información de contacto de la compañía aseguradora

THE TRAVELERS INSURANCE COMPANIES

(800) 238-6225



DEPARTAMENTO DE  
TRABAJO E INDUSTRIA

(651) 284-5032 • 1-800-342-5354 • dli.workcomp@state.mn.us • www.dli.mn.gov

Se requiere la publicación de este aviso por ley en un lugar donde los empleados puedan verlo fácilmente.

Agosto de 2017