

INTRODUCTION

The Texas Amendatory Endorsement must be attached to all policies providing coverage in Texas. Only general and special Texas endorsements approved for use in Texas and contained in this Texas Manual may be used.

Carriers may use their own numbering system in addition to the uniform numbers shown. However, reference on the Information Page pertaining to individual risks must indicate only the numbers as assigned herein. Endorsements containing optional provisions must either be attached or the Information Page must clearly show the option selected. Endorsements must indicate the policy number to which they apply, the name of the insured, the endorsement effective date, and the endorsement issue date or a sequential number indicating the order of issuance.

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TEXAS WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY MANUAL

ENDORSEMENTS & FORMS

Effective July 1, 2011

10th Reprint

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DEFENSE BASE ACT COVERAGE ENDORSEMENT

This endorsement applies only to the work described in the Schedule or described on the Information Page as subject to the Defense Base Act. The policy applies to that work as though the location included in the description of the work were a state named in Item 3.A. of the Information Page.

General Section **C. Workers' Compensation Law** is replaced by the following: *

C. Workers' Compensation Law *

Workers' Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Defense Base Act (42 USC Sections 1651-1654). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits. *

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Defense Base Act. *

Schedule

Description of Work:

Notes:

1. The Defense Base Act makes the Longshore and Harbor Workers' Compensation Act apply to contractors performing work at overseas military bases, whether in a territory or possession of the United States or in a foreign country, and to various public works contracts performed outside the continental United States. *
2. Use this endorsement to provide workers compensation insurance and employers' liability insurance for work subject to the Defense Base Act extension of the Longshore and Harbor Workers' Compensation Act. *
3. The description of the work must include the location where the work is to be performed.

FEDERAL COAL MINE SAFETY AND HEALTH ACT COVERAGE ENDORSEMENT

*

This endorsement applies only to work in a state shown in the Schedule and subject to the Federal Coal Mine Safety and Health Act (30 U.S.C. Sections 801-945). Part One (Workers Compensation Insurance) applies to that work as though that state were shown in Item 3.A. of the Information Page. *

The definition of workers compensation law includes the Federal Coal Mine Safety and Health Act (30 U.S.C. Sections 801-945) and any amendment to that law that is in effect during the policy period. *

Part One (Workers Compensation Insurance), section A.2., How This Insurance Applies, is replaced by the following:

Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period or, when the last exposure occurred prior to July 1, 1973, a claim based on that disease must be first filed against you during the policy period shown in Item 2 of the Information Page.

Schedule

State

Notes:

1. Use this endorsement when the policy is to cover exposures subject to the Federal Coal Mine Safety and Health Act. *
2. Federal Black Lung workers compensation insurance is provided in a state (including monopolistic state fund states) by naming the state in the Schedule.
3. If this endorsement is used with a policy that does not provide any state workers compensation insurance, the insurer may enter the words "no coverage," or "none," or the equivalent, in Item 3.A. of the Information Page.

FEDERAL EMPLOYERS' LIABILITY ACT COVERAGE ENDORSEMENT

This endorsement applies only to work subject to the Federal Employers' Liability Act (45 USC Sections 51-60) and any amendment to that Act that is in effect during the policy period.

G. **Limits of Liability** of Part Two (Employers Liability Insurance) is replaced by the following

G. Limits of Liability

Our Liability to pay for damages is limited. Our limits of liability are shown in the Schedule. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident - each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. Bodily Injury by Disease. The limit shown for "bodily injury by disease - aggregate" is the most we will pay for all damages covered by this insurance because of bodily injury by disease to one or more employees. The limit applies separately to bodily injury by disease arising out of work in each state shown in Item 3.A. of the Information Page or in the Schedule.

Bodily injury by disease does not include disease that results directly from bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

If any state is named in Item 2 of the Schedule, Part Two (Employers Liability Insurance) applies in that state to work subject to the Federal Employers' Liability Act as though that state were listed in Item 3.A. of the Information Page. Part One (Workers Compensation Insurance) does not apply in a state shown in the Schedule.

Schedule

1. Limits of Liability

Bodily Injury by Accident	\$ _____	each accident
Bodily Injury by Disease	\$ _____	aggregate

2. State

Notes:

1. The Federal Employers' Liability Act makes an interstate railroad liable for bodily injuries sustained by an employee. That liability of the railroad is insured by Part Two (Employers Liability Insurance) unless specifically excluded by Federal Employers' Liability Act Exclusion Endorsement.
2. Use this endorsement when providing Federal Employers' Liability Act coverage under Program I or II of Rule XIII of the Basic Manual.
3. Item 2 of the schedule may be used to extend FELA coverage to a state not listed in Item 3.A. of the Information Page.

LONGSHORE AND HARBOR WORKERS' COMPENSATION ACT COVERAGE ENDORSEMENT *

This endorsement applies only to work subject to the Longshore and Harbor Workers' Compensation Act in a state shown in the Schedule. The policy applies to that work as though that state were listed in Item 3.A. of the Information Page. *

General Section **C. Workers' Compensation Law** is replaced by the following: *

C. Workers' Compensation Law *

Workers' Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits. *

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Longshore and Harbor Workers' Compensation Act. *

This endorsement does not apply to work subject to the Defense Base Act, the Outer Continental Shelf Lands Act, or the Nonappropriated Fund Instrumentalities Act.

Schedule

<u>State</u>	<u>Longshore and Harbor Workers' Compensation Act Coverage Percentage</u>	*
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The rates for classifications with code numbers not followed by the letter "F" are rates for work not ordinarily subject to the Longshore and Harbor Workers' Compensation Act. If this policy covers work under such classifications, and if the work is subject to the Longshore and Harbor Workers' Compensation Act, those non-F classification rates will be increased by the Longshore and Harbor Workers' Compensation Act Coverage Percentage shown in the Schedule. *

Notes:

1. The Longshore and Harbor Workers' Compensation Act is a federal workers' compensation law that applies to workers in maritime employments, including longshore and harbor workers, shipbuilders, shipbreakers and ship repairers. It does not apply to masters or crews of vessels or persons unloading vessels under 18 tons net. See Rule XII of the Basic Manual for additional details. *
2. Use this endorsement to provide workers compensation insurance and employers' liability insurance for work subject to the Longshore and Harbor Workers' Compensation Act in any state, including a monopolistic state fund state. *
3. Coverage is provided in a state by naming the state in the Schedule.
4. The following entry may be typed or printed in the Schedule to provide coverage in Item 3.A. states.
"Each state named in Item 3.A. of the Information Page."
5. The following entry may be typed or printed in the Schedule to provide coverage in Item 3.A. and 3.C. states.
"Each state named in Item 3.A. or 3.C. of the Information Page."

NONAPPROPRIATED FUND INSTRUMENTALITIES ACT COVERAGE ENDORSEMENT

This endorsement applies only to the work described in the Schedule or described on the Information Page as subject to the Nonappropriated Fund Instrumentalities Act. The policy applies to that work as though the location shown in the Schedule were a state named in Item 3.A. of the Information Page.

General Section **C. Workers' Compensation Law** is replaced by the following: *

C. Workers' Compensation Law *

Workers' Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173). It includes any amendments to those laws that are in effect during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits. *

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Nonappropriated Fund Instrumentalities Act. *

Schedule

Description and Location of Work:

Notes:

1. The Nonappropriated Fund Instrumentalities Act makes the Longshore and Harbor Workers' Compensation Act apply to civilian employees of certain instrumentalities such as the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Ship's Stores Ashore, Navy, Marine and Coast Guard Exchanges and other instrumentalities of the United States under jurisdiction of the Armed Forces conducted for the pleasure and improvement of Armed Forces personnel. *
2. Use this endorsement to provide workers compensation insurance and employers liability insurance for work subject to the Nonappropriated Fund Instrumentalities Act.

OUTER CONTINENTAL SHELF LANDS ACT COVERAGE ENDORSEMENT

This endorsement applies only to the work described in Item 4 of the Information Page or in the Schedule as subject to the Outer Continental Shelf Lands Act. The policy will apply to that work as though the location shown in the Schedule were a state named in Item 3.A. of the Information Page.

General Section **C. Workers' Compensation Law** is replaced by the following:

C. Workers' Compensation Law

Workers' Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item 3.A. of the Information Page and the Outer Continental Shelf Lands Act (43 U.S.C. Sections 1331-1356a). It includes any amendments to those laws that are in effect * during the policy period. It does not include any other federal workers or workmen's compensation law, other federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

Part Two (Employers Liability Insurance), C. Exclusions., exclusion 8, does not apply to work subject to the Outer Continental Shelf Lands Act.

Schedule

Description and Location of Work:

Notes:

1. The Outer Continental Shelf Lands Act makes the Longshore and Harbor Workers' Compensation Act apply to work involving the development of the natural resources of the Outer Continental Shelf. Use this endorsement to provide workers compensation insurance and employers liability insurance for work on the Outer Continental Shelf subject to the Longshore and Harbor Workers' Compensation Act.
2. The description of the work must show the state whose boundaries, if extended to the Outer Continental Shelf, would include the location of the work.
3. Use the Maritime Exclusion Endorsement or Maritime Coverage Endorsement to exclude or cover the exposure for masters and members of the crews of vessels.

MARITIME COVERAGE ENDORSEMENT

This endorsement changes how insurance provided by Part Two (Employers Liability Insurance) applies to bodily injury to a master or member of the crew of any vessel. *

A. **How This Insurance Applies** is replaced by the following.

A. **How This Insurance Applies**

This insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to work described in Item 1 of the Schedule of the Maritime Coverage Endorsement.
3. The bodily injury must occur in the territorial limits of, or in the operation of a vessel sailing directly between the ports of, the continental United States of America, Alaska, Hawaii or Canada.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
6. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions or Canada.

C. **Exclusions** is changed by removing exclusion 10 and by adding exclusions 13 and 14. *

This insurance does not cover:

13. bodily injury covered by a Protection and Indemnity Policy or similar policy issued to you or for your benefit. This exclusion applies even if the other policy does not apply because of an other insurance clause, deductible or limitation of liability clause, or any similar clause. *
14. your duty to provide transportation, wages, maintenance and cure. This exclusion does not apply if a premium entry is shown in Item 2 of the Schedule. *

D. **We Will Defend** is changed by adding the following statement.

We will treat a suit or other action in rem against a vessel owned or chartered by you as a suit against you.

G. **Limits of Liability**

Our liability to pay for damages is limited. Our limits of liability are shown in the Schedule. They apply as explained below.

1. Bodily Injury by Accident. The limit shown for "bodily injury by accident - each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

- 2. Bodily Injury by Disease. The limit shown for "bodily injury by disease - aggregate" is the most we will pay for all damages covered by this insurance because of bodily injury by disease to one or more employees. The limit applies separately to bodily injury by disease arising out of work in each state shown in Item 3.A. of the Information Page. Bodily injury by disease will be deemed to occur in the state of the vessel's home port.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

- 3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

Schedule

- 1. Description of work:
- 2. Transportation, Wages, Maintenance and Cure Premium \$
- 3. Limits of Liability

Bodily Injury by Accident	\$_____	each accident
Bodily Injury by Disease	\$_____	aggregate

Notes:

- 1. Use this endorsement to afford maritime coverage under Program I or II of Manual Rule XIII.
- 2. Use Item 1 of the Schedule to describe the maritime operations that are to be insured by this endorsement. The description may include limitations by size, ownership or name of vessel and limitations by names of waterways to be used by the vessels.
- 3. Show a premium charge or other appropriate entry in Item 2 to provide coverage for transportation, wages, maintenance and cure.

VOLUNTARY COMPENSATION MARITIME COVERAGE ENDORSEMENT

This endorsement adds Voluntary Compensation Maritime Insurance to the policy.

A. How This Insurance Applies

This insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must be sustained by an employee who is a master or member of the crew of a vessel described in the Schedule.
2. The bodily injury must occur in employment that is necessary or incidental to work described in Item 2 of the Schedule.
3. The bodily injury must occur in the territorial limits of, or in the operation of a vessel sailing directly between the ports of, the continental United States of America, Alaska, Hawaii or Canada.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay an amount equal to the benefits that would be required of you if you and your employees described in Item 1 of the Schedule were subject to the workers compensation law shown in Item 1 of the Schedule. We will pay those amounts to the persons who would be entitled to them under that law.

C. Exclusions

This insurance does not cover:

1. any obligation imposed by a workers compensation or occupational disease law, or any similar law.
2. bodily injury intentionally caused or aggravated by you.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

Schedule

1. EmployeesWorkers' Compensation Law

Master and members of the crews of these vessels:

2. Description of Work:

Notes:

1. Use this endorsement to provide Voluntary Compensation Insurance under Program II of Manual Rule XIII for masters and members of the crews of vessels.
2. This endorsement provides voluntary compensation to the employees described in the Schedule. Employees are described by naming or describing the vessel to which they are attached.
3. When this endorsement is used, the Maritime Coverage Endorsement must also be attached to the policy.

ALTERNATE EMPLOYER ENDORSEMENT

This endorsement applies only with respect to bodily injury to your employees while in the course of special or temporary employment by the alternate employer in the state named in the Schedule. Part One (Workers Compensation Insurance) and Part Two (Employers Liability Insurance) will apply as though the alternate employer is insured.

Under Part One (Workers Compensation Insurance) we will reimburse the alternate employer for the benefits required by the workers compensation law if we are not permitted to pay the benefits directly to the persons entitled to them.

The insurance afforded by this endorsement is not intended to satisfy the alternate employer's duty to secure its obligations under the workers compensation law. We will not file evidence of this insurance on behalf of the alternate employer with any government agency.

We will not ask any other insurer of the alternate employer to share with us a loss covered by this endorsement.

Premium will be charged for employees while in the course of special or temporary employment by the alternate employer.

The policy may be canceled according to its terms without sending notice to the alternate employer.

Part Four (Your Duties If Injury Occurs) applies to you and the alternate employer. The alternate employer will recognize our right to defend under Parts One and Two and our right to inspect under Part Six.

Schedule

<u>Alternate Employer</u>	<u>Address</u>	<u>State of Special or Temporary Employment</u>
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Notes:

1. This endorsement may be used when the insured named in Item 1 of the Information Page has agreed to provide insurance against workers compensation and employers liability claims made by employees of the insured against a special or temporary employer named in the endorsement Schedule.
2. This endorsement may be used only if the state of temporary or special employment is a state shown in Item 3.A. of the Information Page.
3. If the insured is in the business of providing temporary workers for others, the insurer may show the alternate employers in the Schedule by the words "all" or "any."
4. Three uses of this endorsement are illustrated here.
 - a. Use this endorsement if the policy is issued to a contractor (the insured) who is required by an oil company (as alternate or special employer) to provide workers compensation and employers liability insurance to protect the oil company from claims brought by the contractor's employees.
 - b. Use this endorsement if the policy is issued to a business that operates and manages property for others (the insured) who is required by the property owner (the alternate employer) to provide this insurance to protect the owner from claims brought by employees of the operator/manager.
 - c. Use this endorsement if the policy is issued to a supplier of temporary office help (the insured) who is required by its customer (the user of the temporary office help - the alternate employer) to provide this insurance to protect the customer from claims brought by the insured's employees against the alternate employer.
5. If this endorsement is used because of temporary or special employment in Illinois, the carrier must send a written notice of cancellation to all Illinois Alternate Employers shown in the Schedule.

DESIGNATED WORKPLACES EXCLUSION ENDORSEMENT

The policy does not cover work conducted at or from _____.

Notes:

1. Use this endorsement to exclude designated workplaces only when it is proper to do so under the workers compensation law. The use of this endorsement is also limited by Note 2.
2. Use the blank space in the endorsement to carefully describe the work or workplace to be excluded.
 - a. Example excluding an office address:
(Street, City, State)
 - b. Example excluding a construction site:
"or in connection with the construction of..." (describe the project, location, contract, etc.)
 - c. Example covering a location and excluding all others within a state:
"any place in the State of _____ except (Street, City)."
 - d. Example excluding work insured by another policy:
"any workplace covered by insurance policy number _____ issued by Blank Insurance Company."

INSURANCE COMPANY AS INSURED ENDORSEMENT

The policy does not cover your obligations as a workers compensation reinsurer or insurer of other employers. *

Note:

Use this endorsement if the insured is licensed to write workers compensation insurance or reinsurance.

JOINT VENTURE AS INSURED ENDORSEMENT

If the employer named in Item 1 of the Information Page is a joint venture, and if you are one of its members, you are insured, but only in your capacity as an employer of the joint venture's employees.

Note:

Use this endorsement to insure the members of a joint venture named in Item 1 of the Information Page.

RURAL ELECTRIFICATION ADMINISTRATION ENDORSEMENT

1. We will submit our policy and endorsement forms to the Rural Electrification Agency prior to using them.
2. We will mail to the Rural Electrification Agency at least ten days advance notice of the termination of the policy.
3. If you are immune from tort liability, we will not use that immunity as a defense unless you so request us. You agree that waiving the defense of immunity will not make us liable for any payment in excess of the limits of liability stated in the policy.

Note:

Use this endorsement if the insured is a rural electrification cooperative and this endorsement is required by the R.E.A.

VOLUNTARY COMPENSATION AND EMPLOYERS LIABILITY COVERAGE ENDORSEMENT

This endorsement adds Voluntary Compensation Insurance to the policy.

A. How This Insurance Applies

This insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must be sustained by an employee included in the group of employees described in the Schedule.
2. The bodily injury must occur in the course of employment necessary or incidental to work in a state listed in the Schedule.
3. the bodily injury must occur in the United States of America, its territories or possessions, or Canada, and may occur elsewhere if the employee is a United States or Canadian citizen temporarily away from those places.
4. Bodily injury by accident must occur during the policy period.
5. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay an amount equal to the benefits that would be required of you if you and your employees described in the Schedule were subject to the workers compensation law shown in the Schedule. We will pay those amounts to the persons who would be entitled to them under the law.

C. Exclusions

This insurance does not cover:

1. any obligation imposed by a workers compensation or occupational disease law, or any similar law.
2. bodily injury intentionally caused or aggravated by you.

D. Before We Pay

Before we pay benefits to the persons entitled to them, they must:

1. Release you and us, in writing, of all responsibility for the injury or death.
2. Transfer to us their right to recover from others who may be responsible for the injury or death.
3. Cooperate with us and do everything necessary to enable us to enforce the right to recover from others.

If the persons entitled to the benefits of this insurance fail to do those things, our duty to pay ends at once. If they claim damages from you or from us for the injury or death, our duty to pay ends at once.

E. Recovery From Others

If we make a recovery from others, we will keep an amount equal to our expenses of recovery and the benefits we paid. We will pay the balance to the persons entitled to it. If the persons entitled to the benefits of this insurance make a recovery from others, they must reimburse us for the benefits we paid them.

F. Employers Liability Insurance

Part Two (Employers Liability Insurance) applies to bodily injury covered by this endorsement as though the State of Employment shown in the Schedule were shown in Item 3.A. of the Information Page.

Schedule

<u>Employees</u>	<u>State of Employment</u>	<u>Designated Workers' Compensation Law</u>
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Notes:

1. Use this endorsement to afford voluntary compensation coverage pursuant to Rules II and VIII of the Basic Manual.
2. Use Voluntary Compensation Maritime Endorsement to provide Voluntary Compensation Coverage under Program II of Manual Rule XIII.
3. Work in a monopolistic state fund state should not be included in the Schedule unless employers liability coverage is provided in that state by the Employers Liability Coverage Endorsement.
4. Various uses of this endorsement are illustrated below.

Schedule

<u>Employees</u>	<u>State of Employment</u>	<u>Designated Workers Compensation Law</u>
All officers and employees not subject to the Workers Compensation Law.	Any state shown in Item 3.A. of the Information Page	The state where the injury takes place.
All domestics, farm and agricultural workers.	Utah	Utah
All partners of the insured partnership.	Kansas	Kansas

DOMESTIC AND AGRICULTURAL WORKERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we are required to make because of bodily injury to such persons.

Schedule

Farm or Agricultural Workers:

Domestic or Household Workers:

Notes:

1. Use this endorsement in a state where the insured has elected pursuant to the workers compensation law **not** to be responsible for providing benefits for farm or agricultural workers and employees and to exclude employers liability coverage where the insured is statutorily exempt from workers compensation coverage.
2. Use this endorsement in a state where the insured has elected pursuant to the workers compensation law **not** to be responsible for providing benefits for domestic or household workers and to exclude employers liability coverage where the insured is statutorily exempt from workers compensation coverage.
3. Individuals may be designated by naming them or by describing them, for example:
 - a. all farm or agricultural workers.
 - b. all domestic or household workers.

AIRCRAFT PREMIUM ENDORSEMENT

Additional premium is charged for each aircraft shown in the Schedule. The additional premium is subject to adjustment if you have an experience rating modification factor or if this policy is canceled. You may substitute one aircraft for another without additional charge if the substitute aircraft has no more seats than the aircraft shown in the Schedule.

Schedule

<u>State</u>	<u>Aircraft</u>	<u>Passenger Seat Charge</u>	<u>Maximum Charge</u>	<u>Estimated Premium</u>
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Notes:

1. Use this endorsement to show the additional premium required for classification code number 7421.
2. Show the state rates to which the payroll of classification 7421 is assigned.

POLICY PERIOD ENDORSEMENT

The policy period shown in item 2 of the Information Page consists of the consecutive periods shown in the Schedule. Our Manuals and all provisions of the policy apply separately to each period.

Schedule

From _____	to _____	12:01 A.M.
From _____	to _____	12:01 A.M.
From _____	to _____	12:01 A.M.

Notes:

1. Use this endorsement if the policy period is longer than one year and sixteen days and does not consist of complete twelve month periods.
2. Rule III-C of the Basic Manual requires this endorsement to show which period, the first or the last, is to be less than twelve months.

PREMIUM DISCOUNT ENDORSEMENT

The premium for this policy and the policies, if any, listed in Item 3 of the Schedule may be eligible for a discount. This endorsement shows your estimated discount in Item 1 or 2 of the Schedule. The final calculation of premium discount will be determined by our manuals and your premium basis as determined by audit. Premium subject to retrospective rating is not subject to premium discount.

Schedule

	First	Estimated Eligible Premium		Balance
		Next	Next	
1. <u>State</u>	\$5,000	\$95,000	\$400,000	
2. Average percentage discount: _____ %				
3. Other policies:				
4. If there are no entries in Items 1, 2 and 3 of the Schedule see the Premium Discount Endorsement attached to your policy number:				

Notes:

1. Use this endorsement to show the application of Manual Rule VII, Premium Discount, or to identify the insured's policy which shows the application of the Discount Rule.
2. Do not make entries in Items 1, 2 or 3 if a policy number is to be shown in Item 4.
3. The company has the option of replacing Item 1 with the appropriate Table in use by the company. The company may also revise Item 1 to conform to Manual Rules applicable to certain states.
4. Item 2 may be used if all eligible premium is developed in one or more states using the same discount.
5. Item 3 is available to list all policies that are combined under the Discount Rule.
6. Use Item 4 if premium discount is shown on another policy issued to the insured.

TEXAS AMENDATORY ENDORSEMENT

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

GENERAL SECTION

B. **Who is Insured** is amended to read:

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership or joint venture, and if you are one of its partners or members, you are insured, but only in your capacity as an employer of the partnership's or joint venture's employees.

D. **State** is amended to read:

State means any state or territory of the United States of America, and the District of Columbia.

PART ONE - WORKERS' COMPENSATION INSURANCE

E. **Other Insurance** is amended by adding this sentence:

This section only applies if you have other insurance or are self-insured for the same loss.

F. **Payments You Must Make**

This section is amended by deleting the words "workers compensation" from number 4.

H. **Statutory Provisions**

This section is amended by deleting the words "after an injury occurs" from number 2.

PART TWO - EMPLOYERS' LIABILITY INSURANCE

C. **Exclusions**

Sections 2 and 3 are amended to add:

This exclusion does not apply unless the violation of law caused or contributed to the bodily injury.

Section 6 is amended to read:

6. bodily injury occurring outside the United States of America, its territories or possessions, and Canada.
This exclusion does not apply to bodily injury to a citizen or resident of the United States of America, Mexico or Canada who is temporarily outside these countries.

D. **We Will Defend**

This section is amended by deleting the last sentence.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Number 6 of this part is amended to read:

6. Texas law allows you to make weekly payments to an injured employee in certain instances. Unless authorized by law, do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. **Our Manuals** is amended by adding the sentence:

In this part, "our manuals" means manuals approved or prescribed by the Texas Department of Insurance.

C. **Remuneration**

Number 2 is amended to read:

2. All other persons engaged in work that would make us liable under Part One (Workers' Compensation Insurance) of this policy. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured workers' compensation insurance.

E. **Final Premium**

Number 2 is amended to read:

2. If you cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.

PART SIX - CONDITIONS

A. **Inspection** is amended by adding this sentence:

Your failure to comply with the safety recommendations made as a result of an inspection may cause the policy to be cancelled by us.

C. **Transfer of Your Rights and Duties** is amended to read:

Your rights and duties under this policy may not be transferred without our written consent. If you die, coverage will be provided for your surviving spouse or your legal representative. This applies only with respect to their acting in the capacity as an employer and only for the workplaces listed in Items 1 and 4 on the Information Page.

D. **Cancellation** is amended to read:

1. You may cancel this policy. You must mail or deliver advance notice to us stating when the cancellation is to take effect.
2. We may cancel this policy. We may also decline to renew it. We must give you written notice of cancellation or nonrenewal. That notice will be sent certified mail or delivered to you in person. A copy of the written notice will be sent to the Texas Workers' Compensation Commission.
3. Notice of cancellation or nonrenewal must be sent to you not later than the 30th day before the date on which the cancellation or nonrenewal becomes effective, except that we may send the notice not later than the 10th day before the date on which the cancellation or nonrenewal becomes effective if we cancel or do not renew because of:
 - a. Fraud in obtaining coverage;
 - b. Misrepresentation of the amount of payroll for purposes of premium calculation; *
 - c. Failure to pay a premium when payment was due; *
 - d. An increase in the hazard for which you seek coverage that results from an action or omission and that would produce an increase in the rate, including an increase because of failure to comply with reasonable recommendations for loss control or to comply within a reasonable period with recommendations designed to reduce a hazard that is under your control; *
 - e. A determination by the Commissioner of Insurance that the continuation of the policy would place us in violation of the law, or would be hazardous to the interests of subscribers, creditors, or the general public. *

- 4. If another insurance company notifies the Texas Workers' Compensation Commission that it is insuring you as an employer, such notice shall be a cancellation of this policy effective when the other policy starts.

PART SEVEN - OUR DUTY TO YOU FOR CLAIM NOTIFICATION

A. Claims Notification

We are required to notify you of any claim that is filed against your policy. Thereafter, we shall notify you of any proposal to settle a claim or, on receipt of a written request from you, of any administrative or judicial proceeding relating to the resolution of a claim, including a benefit review conference conducted by the Texas Workers' Compensation Commission. You may, in writing, elect to waive this notification requirement.

We shall, on the written request from you, provide you with a list of claims charged against your policy, payments made and reserves established on each claim, and a statement explaining the effect of claims on your premium rates. We must furnish the requested information to you in writing no later than the 30th day after the date we receive your request. The information is considered to be provided on the date the information is received by the United States Postal Service or is personally delivered.

COMPLAINT NOTICE: SHOULD ANY DISPUTE ARISE ABOUT YOUR PREMIUM OR ABOUT A CLAIM THAT YOU HAVE FILED, CONTACT THE AGENT OR WRITE TO THE COMPANY THAT ISSUED THE POLICY. IF THE PROBLEM IS NOT RESOLVED, YOU MAY ALSO WRITE THE TEXAS DEPARTMENT OF INSURANCE, P. O. BOX 149091, AUSTIN, TEXAS 78714-9091, FAX # (512) 475-1771. THIS NOTICE OF COMPLAINT PROCEDURE IS FOR INFORMATION ONLY AND DOES NOT BECOME A PART OR CONDITION OF THIS POLICY.

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 _____

TEXAS VOLUNTEER WORKERS COVERAGE ENDORSEMENT

This policy covers bodily injury under the workers compensation law to the volunteer personnel of political subdivisions and emergency service organizations described in the Schedule.

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

Schedule

Volunteer(s)/Volunteer Member(s):

Notes:

1. Use this endorsement to provide coverage for volunteer workers pursuant to Section 406.098 and Section 504.012, Texas Labor * Code, as amended.
2. The volunteer/volunteer member may be designated by name or classification.

TEXAS WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

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

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule, but this waiver applies only with respect to bodily injury arising out of the operations described in the Schedule where you are required by a written contract to obtain this waiver from us.

This endorsement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

The premium for this endorsement is shown in the Schedule.

Schedule

1. () Specific Waiver

Name of person or organization

() Blanket Waiver

Any person or organization for whom the Named Insured has agreed by written contract to furnish this waiver.

2. Operations:

3. Premium

The premium charge for this endorsement shall be _____ percent of the premium developed on payroll in connection with work performed for the above person(s) or organization(s) arising out of the operations described.

*

* 4. Advance Premium

Notes:

1. Use this endorsement to effect a waiver of recovery from others in accordance with Rule II, Section G, of the Texas Workers' Compensation Manual.
2. If blanket waiver of recover from others is written, the following wording should be inserted following Operations in schedule: All Texas Operations.

TEXAS EXEMPT EMPLOYEES COVERAGE ENDORSEMENT

This policy covers bodily injury under the workers' compensation law to the persons described in the Schedule. *

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

Schedule

Employee or Classification of Employee:

Notes:

1. Use this endorsement to provide coverage for exempt employees pursuant to Section 406.091, Texas Labor Code, as amended. *
2. The employee may be designated by name or classification.

PARTNERS, OFFICERS AND OTHERS EXCLUSION ENDORSEMENT

The policy does not cover bodily injury to any person described in the Schedule.

The premium basis for the policy does not include the remuneration of such persons.

You will reimburse us for any payment we must make because of bodily injury to such persons.

Schedule

PartnersOfficersOthersSole Proprietor**NOTE:**

1. A corporate executive officer(s) with at least 25% equity ownership in the named insured may be excluded from coverage.
2. A corporate executive officer(s) with less than 25% equity ownership in the named insured may be excluded from coverage at the insurer's option.
3. Partners, sole proprietors and spouse(s) thereof that are active in the operation of the named insured may be excluded from coverage.
4. Individuals may be designated in this endorsement only when it is proper to do so under the workers' compensation law. Individuals may be designated by naming them or by describing them, as, for example:
 - a. all partners;
 - b. all executive officers, except the president;
 - c. each person named in Item 4 of the Information Page.

SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE ENDORSEMENT

Pursuant to Section 406.097, Labor Code, sole proprietors, partner(s) or corporate executive officer(s) of the named insured are covered under this workers' compensation policy, unless specifically excluded from coverage through an endorsement to the policy. Such persons may be named in the Schedule below and the premium basis for the policy shall include their remuneration.

For employees excluded from workers' compensation coverage by law, an election has been made by or on behalf of each person described in "Others" in the Schedule to be subject to the workers' compensation law of the state named in the Schedule. Such persons shall be named in the Schedule below and the premium basis for the policy shall include their remuneration.

Schedule

PersonsState

Sole Proprietor:

Partners:

Officers:

Others:

Note:

Individuals may be designated in this endorsement only when it is proper to do so under the workers' compensation law. Individuals may be designated by naming them or by describing them, as, for example:

- a. all partners;
- b. all executive officers except the president;
- c. each person named in Item 4 of the Information Page;
- d. specific names of real estate salespersons licensed under The Real Estate License Act and working solely by commission;
- e. specific name of a family member of the employer on a workers' compensation policy covering farm or ranch employees.

TEXAS ANNIVERSARY RATING DATE ENDORSEMENT

The premium for this policy and the experience rating modification factor, if any, may change on your anniversary rating date shown in the Schedule.

Schedule

Anniversary Rating Date _____ (Month) _____ (Day)

Notes:

- 1. The anniversary rating date is explained in Section I, Experience Rating Plan. *
- 2. Use this endorsement to show the insured's normal anniversary rating date if different from the policy effective date.
- 3. The insurer may show the anniversary rating date in item 4 of the Information Page. *

TEXAS EXPERIENCE RATING MODIFIER ENDORSEMENT

*

The premium for the policy will be adjusted by an experience rating modifier, if any, which was not available when the policy was issued. We will issue an endorsement to show the proper factor when it is calculated. *

Notes:

1. This endorsement may be used if the insured's experience rating is not available when the policy is issued. *
2. An entry may be made in the Information Page instead of using this endorsement. *

GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE ENDORSEMENT

This policy is issued subject to a Group Purchase Program authorized under Article 5.57A, Texas Insurance Code. The premium for this policy and other policies, certified in accordance with the Certificate of Approval, specified in the Schedule, may be eligible for premium discount. The determination of premium discount will be made in accordance with manual rules.

Schedule

Certificate of Approval Number

Notes:

1. This endorsement may be used when the insured is a member of a group certified under Article 5.57A of the Texas Insurance Code.
2. Groups of similar businesses, when certified by the Texas Department of Insurance, may purchase individual Workers' Compensation and employers' liability insurance policies for the members. The group has a right to a premium discount based on the combined group premium amount.

4. Date of contract with employee provider firm: _____

5. For the preceding five (5) years, any other name(s) or assumed name(s) under which the Company has done business or operated and each mailing address it has used and a copy of the Company's most recent Form 941 or its equivalent filed with the Internal Revenue Service by the Company:

6. Company's experience modifier most recently issued by the Department before the Company entered into any employee leasing arrangement:

7. Classifications and payroll of leased workers:

_____	\$	_____
_____	\$	_____
_____	\$	_____
_____	\$	_____
_____	\$	_____
_____	\$	_____

8. The policy number and carrier for each workers' compensation policy issued to the Company under each and every name under which the Company has done business in the preceding five (5) years are:

9. The names of every other employee provider firm from which the Company has ever leased workers (and the effective dates for each such contract) are:

- 10. If coverage is with the insurer of last resort: the Company, its officers, directors and affiliates and any entity with an ownership interest in the Company is in good faith eligible to receive workers' compensation insurance; or, if coverage is with the voluntary market: the Company, its officers, directors and affiliates and any entity with an ownership interest in the Company do not owe any workers compensation premium to any current or prior insurer. *

- 11. The Company acknowledges that the insurer has the same rights of audit that the insurer has with regard to the employee provider firm with which the Company has an employee leasing arrangement; and further understands that the insurer may make any adjustments in premium calculations as a result of such audits.

- 12. The Company acknowledges that premiums will be calculated based on the methods described in Paragraph 3 of Part E of Rule IX of the *Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance*. The Company will abide by any rules and regulations of the Texas Workers' Compensation Commission and the Department that are now or may become in the future applicable to it or to employee provider firms.

NOTICE: Before executing this form, you may wish to review Section 32.54 of the Texas Penal Code entitled, "Penalty for Fraudulently Obtaining Workers' Compensation Insurance Coverage."

Name of Client Company

Signature of Authorized Representative of Client Company

Sworn and Subscribed to before me this _____ day of _____, 20 ____ . *

Notary Public

My Commission Expires: _____

Note:

This endorsement is to be used for each client company of an employee provider firm, if applicable.

**TEXAS - AUDIT PREMIUM AND
RETROSPECTIVE PREMIUM ENDORSEMENT**

Section D of Part Five of the policy is replaced by the following provision:

PART FIVE – PREMIUM

D. Premium Payments

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 billing statement or invoice for audit additional premiums and/or retrospective additional premiums establishes the date that the premium is due.

Notes:

Use this endorsement to amend the policy provisions to indicate that the billing statement or invoice establishes the due date for audit additional premiums and retrospective additional premiums if the uncollected premium (either accrued or billed) is to be considered an admitted asset of the insurance company.

TEXAS HEALTH CARE NETWORK ENDORSEMENT

This endorsement indicates that you have elected under this policy to provide workers' compensation health care services to your injured employees through a certified workers' compensation health care network that we have either established or contracted with, as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

We will provide you with information concerning the use of our certified workers' compensation health care network(s) in our service area(s) and your rights and responsibilities as a participant in our network program. This includes information describing the service area(s) applicable to you and your injured employees as required in Rule VI K. of the *Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance*. In accordance with Chapter 1305 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code, we will also provide you with information that is required to be given to your employees, including an employee's notice of network requirements and an employee acknowledgement form.

Your premium may have been reduced because you have agreed to participate in our certified workers' compensation health care network. The amount of the premium reduction is shown on the Information Page of this policy. The reduction is estimated at the policy inception and adjusted at final audit of the policy. The reduction may be pro-rated if you elect to participate in a certified workers' compensation health care network during the policy year or if you terminate your participation in our certified workers' compensation health care network before the policy expires. The premium reduction you received may be forfeited if we determine that you have failed to provide the notice of network requirements and employee acknowledgement form to your employees in accordance with Chapter 1305.005(d) and 1305.451 Texas Insurance Code and Title 28, Chapter 10 of the Texas Administrative Code.

Minimum premium policies are not eligible for this premium reduction.

Notes:

Use this endorsement if the policyholder elects to provide workers' compensation health care services to injured employees through a certified workers' compensation health care network either established by the insurance carrier or contracted with by the insurance carrier as provided in Chapter 1305 of the Texas Insurance Code and in Title 28, Chapter 10 of the Texas Administrative Code.

TEXAS NOTICE OF MATERIAL CHANGE ENDORSEMENT

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

In the event of cancellation or other material change of the policy, we will mail advance notice to the person or organization named in the Schedule. The number of days advance notice is shown in the Schedule.

This endorsement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

Schedule

1. Number of days advance notice:
2. Notice will be mailed to:

Note:

Use this endorsement if Texas is shown in Item 3.A. of the Information Page and the insurer agrees to give to a third party advance notice of cancellation or other material change.

TEXAS ACCIDENT DEDUCTIBLE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers Compensation Insurance) because Texas is shown in Item 3.A. of the Information Page.

1. Part One (Workers Compensation Insurance) applies only to benefits in excess of the deductible amount shown in the Schedule below. This deductible applies separately to each person who sustains bodily injury by disease and separately to all bodily injuries arising out of any one accident covered under the policy.
2. We will pay the deductible amount for you, but you must reimburse us within 30 days after we send you notice that payment is due. We will send you notice that payment is due on a periodic basis, but not more frequently than on a monthly basis. If you fail to fully reimburse us when due, we may cancel the policy for nonpayment of premium. We may keep the amount of unearned premium that will reimburse us for the payments we made. These rights are in addition to other rights we have to be reimbursed.

Schedule

Accident Deductible Amount**Notes:**

1. The amount to be inserted in the Schedule is (insert deductible amounts) at the option of the insured.
2. Do not use this endorsement if the insured elects an aggregate deductible or both a per accident and aggregate deductible.

TEXAS AGGREGATE DEDUCTIBLE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers' Compensation Insurance) because Texas is shown in Item 3.A. of the Information Page.

1. Part One (Workers' Compensation Insurance) applies only to benefits in excess of the aggregate deductible amount shown in the Schedule below. This deductible applies to claims compensable under the Texas Workers' Compensation Law.
2. The aggregate deductible amount shown in the Schedule below is the most you must reimburse us for the sum of all medical and indemnity benefits compensable under the Texas Workers' Compensation Law for each policy period.
3. We will pay the deductible amount for you, but you must reimburse us within 30 days after we send you notice that payment is due. We will send you notice that payment is due on a periodic basis, but not more frequently than on a monthly basis. If you fail to fully reimburse us when due, we may cancel the policy for nonpayment of premium. We may keep the amount of unearned premium that will reimburse us for the payments we made. These rights are in addition to other rights we have to be reimbursed.
4. If we cancel the policy, the aggregate deductible amount shown in the Schedule below will be reduced to a * pro rata amount based on the time this policy was in force.

If you cancel the policy, the aggregate deductible amount shown in the Schedule below will not be reduced to * a pro rata amount based on the time this policy was in force.

Schedule

Aggregate Deductible Amount**Notes:**

1. The amount to be inserted in the Schedule is (insert deductible amounts) at the option of the insured.
2. Do not use this endorsement if the insured elects a per accident deductible or both a per accident and aggregate deductible.

TEXAS ACCIDENT/AGGREGATE DEDUCTIBLE ENDORSEMENT

This endorsement applies only to the insurance provided by Part One (Workers' Compensation Insurance) because Texas is shown in Item 3.A. of the Information Page.

1. Part One (Workers' Compensation Insurance) applies only to benefits in excess of the deductible amounts shown in the Schedule below. These deductibles apply to claims compensable under the Texas Workers' Compensation Law.
2. The deductible amount shown in the Schedule below applies separately to each person who sustains bodily injury by disease and separately to all bodily injuries arising out of any one accident covered under the policy.
3. The aggregate deductible amount shown in the Schedule below is the most you must reimburse us for the sum of all medical and indemnity benefits compensable under the Texas Workers' Compensation Law for each policy period.
4. We will pay the deductible amount for you, but you must reimburse us within 30 days after we send you notice that payment is due. We will send you notice that payment is due on a periodic basis, but not more frequently than on a monthly basis. If you fail to fully reimburse us when due, we may cancel the policy for nonpayment of premium. We may keep the amount of unearned premium that will reimburse us for the payments we made. These rights are in addition to other rights we have to be reimbursed.
5. If we cancel the policy, the aggregate deductible amount shown in the Schedule below will be reduced to a * pro rata amount based on the time this policy was in force.

If you cancel the policy, the aggregate deductible amount shown in the schedule below will not be reduced to * a pro rata amount based on the time this policy was in force.

Schedule

Accident Deductible Amount

Aggregate Deductible Amount

Notes:

1. Use this endorsement if the insured elects both a per accident and aggregate deductible.
2. The deductible amount to be inserted in the Schedule is (insert deductible amounts) at the option of the insured.
3. The aggregate deductible amount to be inserted in the Schedule is (insert deductible amounts) at the option of the insured.

DEDUCTIBLE NOTICE OF ELECTION

*

Texas law permits an employer to obtain workers' compensation insurance with a deductible. The insurance * applies only to benefits payable under Texas workers' compensation law. When a deductible is elected, the policyholder is required to reimburse the insurance carrier for benefits payable under the law up to the deductible amount and a credit is applied to the policy. Premium credits are determined based on the deductible selected * and the hazard group. The hazard group is determined by the classification that produces the largest amount of estimated Texas standard premium.

You are not required to choose a deductible. If you do choose one, your insurance company will pay the deductible amount for you, but you must reimburse the insurance company within 30 days after they send you notice that payment is due. If you fail to reimburse the insurance company, they may cancel the policy upon ten days written notice, and any resulting premium may be applied to the deductible amount owed.

If a deductible amount is desired, please indicate below.

Yes, I want a deductible of (select only one):

- 1. \$ _____ per accident
- 2. \$ _____ annual aggregate
- 3. \$ _____ /\$ _____ per accident/annual aggregate

applied to benefits payable under the Texas Workers' Compensation Law. I understand that the company will pay the deductible amount and seek reimbursement _____
(monthly, quarterly or other)

No, I do not want a deductible applied to benefits payable under the Texas Workers' Compensation Law.

Yes, I do want a deductible policy, but am unable to obtain one for the following reason: _____

The deductible plans have been explained to me.

Signature and Title	Date	
Employer Name (print or type)	Address	
Insurance Company	Policy No.	Effective Date

Notes:

- 1. This signed DNE-1 [1-97] form is to be maintained in the insuring carrier's file, regardless of whether the deductible is elected or * rejected, and shall be made available to the Texas Department of Insurance upon specific request.
- 2. Reimbursement is to be made periodically as agreed. Choose "monthly," "quarterly," or other period of time; may not be more frequent than monthly.
- 3. This notice may only be signed by owner, partner, executive officer or authorized person.

6. The name, address and Social Security number of each officer, manager, affiliate, or other entity in control of the Employee Provider and all other employee provider firms for which such officer, manager, affiliate, or entity has worked or in which such officer, manager, affiliate, or entity has or has had an ownership interest:
7. (a) The name and address of each client company:
- (b) The name and address of each entity to which workers were provided for a continuous period of more than six months during the past year or to which workers may be provided for a continuous period of more than six months in the coming year:
- * 8. If coverage is with the insurer of last resort: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider are in good faith eligible to receive workers' compensation insurance; or, if coverage is with the voluntary market: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider do not owe any workers' compensation premium to any current or prior insurers.
9. The Employee Provider will abide by any rules and regulations of the Texas Workers' Compensation Commission and the Department that are now or may become in the future applicable to it.
10. The Employee Provider acknowledges that periodic audits may be conducted at any time after the effective date of the policy for any purpose. The Employee Provider understands that these rights of audit apply also to any of its client companies and has so informed its client companies. The Employee Provider agrees that the insurer may make any adjustments in premium calculations as a result of such audits.
11. The Employee Provider understands that any false or misleading statement, misrepresentation, concealment or omission of a material fact in connection with this Form EP-1 or any Employee Provider/Client Company Endorsement provided by any of its client companies may result in cancellation upon thirty (30) days' notice of its Workers' Compensation insurance policy.

NOTICE: Before executing this form, you may wish to review Section 32.54 of the Texas Penal Code entitled, "Penalty for Fraudulently Obtaining Workers' Compensation Insurance Coverage."

Name of Employee Provider Firm

Signature of Authorized Representative of
Employee Provider Firm

* Sworn and Subscribed to before me this _____ day of _____, 20_____.

Notary Public

My Commission Expires: _____

- 6. The name, address and Social Security number of each officer, manager, affiliate, or other entity in control of the Employee Provider and all other employee provider firms for which such officer, manager, affiliate, or entity has worked or in which such officer, manager, affiliate, or entity has or has had an ownership interest:

- 7. (a) The name and address of each client company:

- (b) The name and address of each entity to which workers were provided for a continuous period of more than six months during the past year or to which workers may be provided for a continuous period of more than six months in the coming year:

- 8. For each client company identified in the preceding subsection, the date the employee leasing arrangement began, the date(s) the employee provider firm began paying premiums for leased workers of each client company, the Employee Provider's experience rating date, the experience modification of each client company as of the date the employee leasing arrangement began, the experience modification(s) upon which premiums were paid by the Employee Provider for leased workers of each client company, and the difference between the premium calculations based on the experience modification of each client company and the experience modification(s) actually used.

- * 9. If coverage is with the insurer of last resort: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider are in good faith eligible to receive workers' compensation insurance; or, if coverage is with the voluntary market: the Employee Provider, its officers, directors, affiliates, and any entity with an ownership interest in the Employee Provider do not owe any workers' compensation premium to any current or prior insurers.

- 10. The Employee Provider will abide by any rules and regulations of the Texas Workers' Compensation Commission and the Department that are now or may become in the future applicable to it.

- 11. The Employee Provider acknowledges that periodic audits may be conducted at any time after the effective date of the policy for any purpose. The Employee Provider understands that these rights of audit apply also to any of its client companies and has so informed its client companies. The Employee Provider agrees that the insurer may make any adjustments in premium calculations as a result of such audits.

- 12. The Employee Provider understands that any false or misleading statement, misrepresentation, concealment or omission of a material fact in connection with this Form EP-1 or any Employee Provider/Client Company Endorsement provided by any of its client companies may result in cancellation upon thirty (30) days' notice of its workers' compensation insurance policy.

NOTICE: Before executing this form, you may wish to review Section 32.54 of the Texas Penal Code entitled, "Penalty for Fraudulently Obtaining Workers' Compensation Insurance Coverage."

Name of Employee Provider Firm

Signature of Authorized Representative of Employee Provider Firm

*Sworn and Subscribed to before me this _____ day of _____, 20____.

Notary Public

My Commission Expires: _____

TEXAS EXPERIENCE RATING FORM

NAME OF RISK

ADDRESS

EFFECTIVE DATE OF RATING

PART I - EXHIBIT OF ACTUAL LOSSES						PART II - EXHIBIT OF EXPECTED LOSSES						
			(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
			POLICY YEAR	ACTUAL INCURRED LOSSES	PRIMARY ACTUAL LOSSES	CLASSIFICATION	POLICY YEAR	PAYROLL	EXPECTED LOSS RATE	EXPECTED LOSSES (9) x (10) ÷ 100	"D" RATIO	PRIMARY EXPECTED LOSSES (11) x (12)
TOTAL BY POLICY YEAR OF ALL CASES \$2,000 OR UNDER												
(1) Claim Number	(2) Kind of Inj.	(3) 0 or 1										
TOTALS			(a)	(b)		*IF RATING IS FOR 1994 OR LATER, MODIFIER MAY BE CAPPED IF TOTAL EXPECTED LOSSES ARE \$15,000 OR LESS.				(d)	(e)	
			(c) ACTUAL EXCESS							(f) EXPECTED EXCESS (d) - (e) =		
PART III - RATING PROCEDURE												
						(14)	(15)					
1. PRIMARY ACTUAL & TOTAL EXPECTED LOSSES												
2. "B" VALUE ENTER IN COLUMNS 14 & 15												
3. RATABLE EXCESS W = (W) x (C) =												
4. (1.00 - W) = ; (F)												
(1.00 - W) x (F) =												
5. TOTALS						(G)	(H)					
6. MODIFIER (G) ÷ (H) =												

REPORT OF EXPERIENCE FOR SELF INSURERS

For Experience Rating Purposes

FILL IN BLANKS WHERE APPLICABLE TO REFLECT INCURRED LOSSES AND PAYROLLS EXPENDED UNDER THE WORKERS' COMPENSATION LAW

Report	Policy Number		Submitting Carrier							Adm. File No.				
Effective Date	Term	Expiration Date		Insured _____										
Cond.	91	92	93	94	95	96	97	98	Other					
Exp. Cov.	Class. Code	EXPOSURE	Manual Rate	PREMIUM	CLAIM NUMBER	ACCIDENT DATE OR NUMBER OF CLAIMS	Class. Code	I N J	INCURRED LOSSES		O P E N	C L O S E D	Loss Cov.	Cat. No.
									Indemnity	Medical				
TOTALS		XXXX		TOTALS		XXXX		X			X	X	XX	X

As submitting carrier, it is hereby certified that the information given in this report is correct to the best of our knowledge and belief.

Signature _____

Official Title _____

AFFIDAVIT

STATE OF TEXAS

County of _____

I, _____, _____ of _____, Texas

Employer, hereby certify that the information given in the foregoing report is correct to the best of my knowledge and belief.

SWORN TO AND SUBSCRIBED before me the undersigned authority by the said _____

on this the _____ day of _____, 20 ____ . *

NOTARY PUBLIC IN AND FOR

**GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE
APPLICATION FOR CERTIFICATION FOR GROUP TO FORM**

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE TEXAS DEPARTMENT OF INSURANCE AT LEAST SIXTY DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE OF THE GROUP'S POLICIES.

CERTIFICATE OF APPROVAL No. _____
The business entities listed on this application are certified to form and maintain a group, in accordance with the Rules and Regulations of Group Purchase of Workers' Compensation Insurance Program. This certificate in no way shall obligate the Texas Department of Insurance to resolve or become involved in the resolution of any disputes and/or claims involving the group and/or members of the group. The Plan of Operation must set forth the procedures to resolve any and all disputes and/or claims that may arise among members and/or potential members of the group.
Approved By: _____ Issue Date: _____

Group: _____

Contact Person: _____

Name	Address
_____	_____
Phone	City/State/Zip Code
_____	_____

Administrator of Group: _____

Name	Address
_____	_____
Phone	City/State/Zip Code
_____	_____

Common Expiration or Pre-determined Premium Discount Evaluation Date of Policies: _____

*

Carrier: _____

	Names of Business Entities to be Included in Group	Location
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

	<u>Policy Effective</u>	<u>WC Governing Class Code</u>	<u>Estimated Premium</u>	<u>Number of Employees</u>	<u>Latest Modifier</u>	<u>Board File No.</u>
1a.	_____	_____	_____	_____	_____	_____
2a.	_____	_____	_____	_____	_____	_____
3a.	_____	_____	_____	_____	_____	_____
4a.	_____	_____	_____	_____	_____	_____

Attach list for additional business entities.

NOTE TO ADMINISTRATOR: The Plan of Operation must accompany this Application and be filed with:

Texas Department of Insurance
W. C. Group Purchase Program, MC 105-2A
P. O. Box 149104
Austin, TX 78714-9104

*

**GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE
RENEWAL APPLICATION FOR CERTIFICATION FOR GROUP TO FORM**

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE TEXAS DEPARTMENT OF INSURANCE AT LEAST THIRTY DAYS PRIOR TO THE RENEWAL DATE OF THE GROUP'S POLICIES.

RENEWAL CERTIFICATE OF APPROVAL No. _____	
The business entities listed on this application are certified to form and maintain a group, in accordance with the Rules and Regulations of Group Purchase of Workers' Compensation Insurance Program. This certificate in no way shall obligate the Texas Department of Insurance to resolve or become involved in the resolution of any disputes and/or claims involving the group and/or members of the group. The Plan of Operation must set forth the procedures to resolve any and all disputes and/or claims that may arise among members and/or potential members of the group.	
Approved By: _____	Issue Date: _____

Group: _____

Contact Person: _____

Name	Address
_____	_____
Phone	City/State/Zip Code
_____	_____

Administrator of Group _____

Name	Address
_____	_____
Phone	City/State/Zip Code
_____	_____

Common Expiration or Pre-determined Premium Discount Evaluation Date of Policies: _____

*

Carrier: _____

	Names of Business Entities to be Included in Group	Location
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

	<u>Policy Effective</u>	<u>WC Governing Class Code</u>	<u>Estimated Premium</u>	<u>Number of Employees</u>	<u>Latest Modifier</u>	<u>Board File No.</u>
1a.	_____	_____	_____	_____	_____	_____
2a.	_____	_____	_____	_____	_____	_____
3a.	_____	_____	_____	_____	_____	_____
4a.	_____	_____	_____	_____	_____	_____

Attach list for additional business entities.

**Texas Department of Insurance
 W. C. Group Purchase Program, MC 105-2A
 P. O. Box 149104
 Austin, TX 78714-9104**

*

REQUEST FOR INFORMATION

The following ownership statements are for use in establishing premiums for your workers' compensation coverages under the Experience Rating Plan. It is extremely important that all questions be answered completely. If you have any questions, contact your agent or your insurance company. Submit the completed form to your insurance company. *

PURPOSE (Check One)

- Name change only**
Complete column A for former name and column B for new name.
Complete only questions 1, 2 and 3 on page 2.
- Combination of separate entities**
Complete a separate column for each entity related through common ownership (attach additional forms if necessary).
- Sale, transfer or conveyance of ownership interest**
Complete column A for ownership before the change and column B for ownership after the change.
- Merger or consolidation**
Complete columns A and B for the former entities and column C for the surviving entity.
- Formation of a new entity**
Complete column A.
- Sale, transfer or conveyance of an entity's physical assets to another entity which takes over its operations**
Complete column A for the former entity and column B for the acquiring entity.

INFORMATION	A	B	C
Name and street address of Entity (P. O. Box Numbers are not acceptable)			
Legal Status of Entity (Corporation, Partnership, Sole Proprietor, Trustee, Receiver, Limited Partnership, etc.)			
Ownership Corporations —List names of owners of 100% voting stock and number of shares owned.* (Submit shareholder proposal if transaction involved exchange of stock.) Partnerships —List each general partner and appropriate share in the profits. (If limited partnership, list name of general partner.) Other —If no voting stock, list members, board of directors or comparable governing body.			
* Total shares of voting stock issued			
Date of Ownership Change, Acquisition, or Combinability			
Insuring Company, Policy Number and Effective Date			

REQUEST FOR INFORMATION

- 1. Has this entity operated under another name in the last four years? _____
- 2. Is the entity **currently** related through common majority ownership to any entity not listed on the front of the form?

- 3. Has this entity been **previously** related through common majority ownership to any other entities in the last four years?

If you answered yes to 1, 2, or 3 above, please provide the following information:

Name of Business	Principal Location	Carrier and Policy Number	Effective Date
------------------	--------------------	---------------------------	----------------

- 4. Were the assets and/or ownership interest (all or a portion) of this entity acquired from a previously existing business?

If yes, you must provide complete ownership information of the prior owner in column A and ownership information on the new owner in column B on the reverse side of this form.
- 5. Did the entity involved also undergo a change in operations sufficient to result in a change to its governing classification? If yes, attach a detailed explanation supporting these changes.
- 6. If this is a partial sale, transfer, or conveyance of an existing business (i.e., sale of one or more plans or locations):
 - a. Explain what portion or location of the entire operation was sold, transferred, or conveyed. _____
 - b. Was this entity insured under a separate policy from the remaining portion? _____ If not, specify the entities with which it was combined: _____
 - c. What entities will the seller maintain majority ownership of after this change? _____

This is to certify that the information contained on this form is complete and correct.

Name of insured: _____

Name of person completing form: _____

Signature of Owner, Partner or Executive Officer

Title

Print name of above signature

Date

WORKERS COMPENSATION AND EMPLOYERS LIABILITY INSURANCE POLICY

In return for the payment of the premium and subject to all terms of this policy, we agree with you as follows:

GENERAL SECTION

A. The Policy

This policy includes at its effective date the Information Page and all endorsements and schedules listed there. It is a contract of insurance between you (the employer named in Item 1 of the Information Page) and us (the insurer named on the Information Page). The only agreements relating to this insurance are stated in this policy. The terms of this policy may not be changed or waived except by endorsement issued by us to be part of this policy.

B. Who Is Insured

You are insured if you are an employer named in Item 1 of the Information Page. If that employer is a partnership, and if you are one of its partners, you are insured, but only in your capacity as an employer of the partnership's employees.

C. Workers Compensation Law

Workers Compensation Law means the workers or workmen's compensation law and occupational disease law of each state or territory named in Item

3.A. of the Information Page. It includes any amendments to that law which are in effect during the policy period. It does not include any federal workers or workmen's compensation law, any federal occupational disease law or the provisions of any law that provide nonoccupational disability benefits.

D. State

State means any state of the United States of America, and the District of Columbia.

E. Locations

This policy covers all of your workplaces listed in Items 1 or 4 of the Information Page; and it covers all other workplaces in Item 3.A. states unless you have other insurance or are self-insured for such workplaces.

PART ONE - WORKERS COMPENSATION INSURANCE

A. How This Insurance Applies

This workers compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers compensation law.

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

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 amount payable under this insurance;
3. litigation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance

We will not pay more than our share of benefits and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is paid.

F. Payments You Must Make

You are responsible for any payments in excess of the benefits regularly provided by the workers compensation law including those required because:

1. of your serious and willful misconduct;
2. you knowingly employ an employee in violation of law;
3. you fail to comply with a health or safety law or regulation; or
4. you discharge, coerce or otherwise discriminate against any employee in violation of the workers compensation law.

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.

G. Recovery From Others

We have your rights, and the rights of persons entitled to the benefits of this insurance, to recover our payments from anyone liable for the injury. You will do everything necessary to protect those rights for us and to help us enforce them.

H. Statutory Provisions

These statements apply where they are required by law.

1. As between an injured worker and us, we have notice of the injury when you have notice.
2. Your default or the bankruptcy or insolvency of you or your estate will not relieve us of our duties under this insurance after an injury occurs.
3. We are directly and primarily liable to any person entitled to the benefits payable by this insurance. Those persons may enforce our duties; so may an agency authorized by law. Enforcement may be against us or against you and us.
4. Jurisdiction over you is jurisdiction over us for purposes of the workers compensation law. We are bound by decisions against you under that law, subject to the provisions of this policy that are not in conflict with that law.
5. This insurance conforms to the parts of the workers compensation law that apply to:
 - a. benefits payable by this insurance;
 - b. special taxes, payments into security or other special funds, and assessments payable by us under that law.
6. Terms of this insurance that conflict with the workers compensation law are changed by this statement to conform to that law.

Nothing in these paragraphs relieves you of your duties under this policy.

PART TWO - EMPLOYERS LIABILITY INSURANCE

A. How This Insurance Applies

This employers liability insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. The bodily injury must arise out of and in the course of the injured employee's employment by you.
2. The employment must be necessary or incidental to your work in a state or territory listed in Item 3.A. of the Information Page.
3. Bodily injury by accident must occur during the policy period.
4. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.
5. If you are sued, the original suit and any related legal actions for damages for bodily injury by accident or by disease must be brought in the United States of America, its territories or possessions, or Canada.

B. We Will Pay

We will pay all sums that you legally must pay as damages because of bodily injury to your employees, provided the bodily injury is covered by this Employers Liability Insurance. *

The damages we will pay, where recovery is permitted by law, include damages:

1. For which you are liable to a third party by reason of a claim or suit against you by that third party to recover the damages claimed against such third party as a result of injury to your employee;
2. For care and loss of services; and
3. For consequential bodily injury to a spouse, child, parent, brother or sister of the injured employee; provided that these damages are the direct consequence of bodily injury that arises out of and in the course of the injured employee's employment by you; and

4. Because of bodily injury to your employee that arises out of and in the course of employment, claimed against you in a capacity other than as employer.

C. Exclusions

This insurance does not cover:

1. Liability assumed under a contract. This exclusion does not apply to a warranty that your work will be done in a workmanlike manner;
2. Punitive or exemplary damages because of bodily injury to an employee employed in violation of law;
3. Bodily injury to an employee while employed in violation of law with your actual knowledge or the actual knowledge of any of your executive officers;
4. Any obligation imposed by a workers compensation, occupational disease, unemployment compensation, or disability benefits law, or any similar law;
5. Bodily injury intentionally caused or aggravated by you;
6. Bodily injury occurring outside the United States of America, its territories or possessions, and Canada. This exclusion does not apply to bodily injury to a citizen or resident of the United States of America or Canada who is temporarily outside these countries;
7. Damages arising out of coercion, criticism, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination against or termination of any employee, or any personnel practices, policies, acts or omissions;
8. Bodily injury to any person in work subject to the Longshore and Harbor Workers' Compensation Act (33 USC Sections 901-950), the Nonappropriated Fund Instrumentalities Act (5 USC Sections 8171-8173), the Outer Continental Shelf Lands Act (43 USC Sections 1331-1356a), the Defense Base Act (42 USC Sections 1651-1654), the Federal Coal Mine Safety and Health Act (30 USC Sections 801-945), any other federal workers or workmen's compensation law or other federal occupational disease law, or any amendments to these laws; *

9. Bodily injury to any person in work subject to the Federal Employers' Liability Act (45 USC Sections 51-60), any other federal laws obligating an employer to pay damages to an employee due to bodily injury arising out of or in the course of employment, or any amendments to those laws;
10. Bodily injury to a master or member of the crew of any vessel;
11. Fines or penalties imposed for violation of federal or state law; and
12. Damages payable under the Migrant and Seasonal Agricultural Worker Protection Act (29 USC Sections 1801-1872) and under any other federal law awarding damages for violation of those laws or regulations issued thereunder, and any amendments to those laws.

D. We Will Defend

We have the right and duty to defend, at our expense, any claim, proceeding or suit against you for damages payable by this insurance. We have the right to investigate and settle these claims, proceedings and suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance. We have no duty to defend or continue defending after we have paid our applicable limit of liability under this insurance.

E. We Will Also Pay

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. Interest on a judgment as required by law until we offer the amount due under this insurance; and
5. Expenses we incur.

F. Other Insurance

We will not pay more than our share of damages and costs covered by this insurance and other insurance or self-insurance. Subject to any limits of liability that apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance and self-insurance will be equal until the loss is paid.

G. Limits of Liability

Our liability to pay for damages is limited. Our limits of liability are shown in Item 3.B. of the Information Page. They apply as explained below.

1. **Bodily Injury by Accident.** The limit shown for "bodily injury by accident—each accident" is the most we will pay for all damages covered by this insurance because of bodily injury to one or more employees in any one accident.

A disease is not bodily injury by accident unless it results directly from bodily injury by accident.

2. **Bodily Injury by Disease.** The limit shown for "bodily injury by disease—policy limit" is the most we will pay for all damages covered by this insurance and arising out of bodily injury by disease, regardless of the number of employees who sustain bodily injury by disease. The limit shown for "bodily injury by disease—each employee" is the most we will pay for all damages because of bodily injury by disease to any one employee.

Bodily injury by disease does not include disease that results directly from a bodily injury by accident.

3. We will not pay any claims for damages after we have paid the applicable limit of our liability under this insurance.

H. Recovery From Others

We have your rights to recover our payment from anyone liable for an injury covered by this insurance. You will do everything necessary to protect those rights for us and to help us enforce them.

I. Actions Against Us

There will be no right of action against us under this insurance unless:

1. You have complied with all the terms of this policy; and
2. The amount you owe has been determined with our consent or by actual trial and final judgment.

This insurance does not give anyone the right to add us as a defendant in an action against you to determine your liability. The bankruptcy or insolvency of you or your estate will not relieve us of our obligations under this Part.

PART THREE - OTHER STATES INSURANCE

A. How This Insurance Applies

1. This other states insurance applies only if one or more states are shown in Item 3.C. of the Information Page.
2. If you begin work in any one of those states after the effective date of this policy and are not insured or are not self-insured for such work, all provisions of the policy will apply as though that state were listed in Item 3.A. of the Information Page.
3. We will reimburse you for the benefits required by the workers compensation law of that state if we

are not permitted to pay the benefits directly to persons entitled to them.

4. If you have work on the effective date of this policy in any state not listed in Item 3.A. of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.

B. Notice

Tell us at once if you begin work in any state listed in Item 3.C. of the Information Page.

PART FOUR - YOUR DUTIES IF INJURY OCCURS

Tell us at once if injury occurs that may be covered by this policy. Your other duties are listed here.

1. Provide for immediate medical and other services required by the workers compensation law.
2. Give us or our agent the names and addresses of the injured persons and of witnesses, and other information we may need.
3. Promptly give us all notices, demands and legal papers related to the injury, claim, proceeding or suit.

4. Cooperate with us and assist us, as we may request, in the investigation, settlement or defense of any claim, proceeding or suit.
5. Do nothing after an injury occurs that would interfere with our right to recover from others.
6. Do not voluntarily make payments, assume obligations or incur expenses, except at your own cost.

PART FIVE - PREMIUM

A. Our Manuals

All premium for this policy will be determined by our manuals of rules, rates, rating plans and classifications. We may change our manuals and apply the changes to this policy if authorized by law or a governmental agency regulating this insurance.

B. Classifications

Item 4 of the Information Page shows the rate and premium basis for certain business or work classifications. These classifications were assigned based on an estimate of the exposures you would have during the policy period. If your actual exposures are not properly described by those classifications, we will assign proper classifications,

rates and premium basis by endorsement to this policy.

C. Remuneration

Premium for each work classification is determined by multiplying a rate times a premium basis. Remuneration is the most common premium basis. This premium basis includes payroll and all other remuneration paid or payable during the policy period for the services of:

1. all your officers and employees engaged in work covered by this policy; and
2. all other persons engaged in work that could make us liable under Part One (Workers Compensation Insurance) of this policy. If you do not have payroll records for these persons, the contract price for their services and materials may be used as the premium basis. This paragraph 2 will not apply if you give us proof that the employers of these persons lawfully secured their workers compensation obligations.

D. Premium Payments

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.

E. Final Premium

The premium shown on the Information Page, schedules, and endorsements is an estimate. The final premium will be determined after this policy ends by using the actual, not the estimated, premium basis and the proper classifications and rates that lawfully apply to the business and work covered by this policy.

If the final premium is more than the premium you paid to us, you must pay us the balance. If it is less, we will refund the balance to you. The final premium will not be less than the highest minimum premium for the classifications covered by this policy.

If this policy is canceled, final premium will be determined in the following way unless our manuals provide otherwise:

1. If we cancel, final premium will be calculated pro rata based on the time this policy was in force. Final premium will not be less than the pro rata share of the minimum premium.
2. If you cancel, final premium will be more than pro rata; it will be based on the time this policy was in force, and increased by our short rate cancellation table and procedure. Final premium will not be less than the minimum premium.

F. Records

You will keep records of information needed to compute premium. You will provide us with copies of those records when we ask for them.

G. Audit

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. Information developed by audit will be used to determine final premium. Insurance rate service organizations have the same rights we have under this provision.

PART SIX - CONDITIONS

A. Inspection

We have the right, but are not obliged to inspect your workplaces at any time. Our inspections are not safety inspections. They relate only to the insurability of the workplaces and the premiums to be charged. We may give you reports on the conditions we find. We may also recommend changes. While they may help reduce losses, we do not undertake to perform the duty of any person to provide for the health or safety of your employees or the public. We do not warrant

that your workplaces are safe or healthful or that they comply with laws, regulations, codes or standards. Insurance rate service organizations have the same rights we have under this provision.

B. Long Term Policy

If the policy period is longer than one year and sixteen days, all provisions of this policy will apply as though a new policy were issued on each annual anniversary that this policy is in force.

C. Transfer of Your Rights and Duties

Your rights or duties under this policy may not be transferred without our written consent.

If you die and we receive notice within thirty days after your death, we will cover your legal representative as insured.

D. 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 not less than ten days advance written notice stating when the cancellation is to take effect. Mailing that notice to you at your

mailing address shown in Item 1 of the Information Page will be sufficient to prove notice.

3. The policy period will end on the day and hour stated in the cancellation notice.
4. Any of these provisions that conflicts with a law that controls the cancellation of the insurance in this policy is changed by this statement to comply with the law.

E. Sole Representative

The insured first named in Item 1 of the Information Page will act on behalf of all insureds to change this policy, receive return premium, and give or receive notice of cancellation.

INFORMATION PAGE

- * Insurer Policy No. _____

- 1. The Insured: __Individual __Partnership
 Mailing address: _____
 Other workplaces not shown above: __Corporation or _____

- 2. The policy period is from _____ to _____ at the insured's mailing address.

- 3. A. Workers Compensation Insurance: Part One of the policy applies to the Workers Compensation Law of the states listed here:

- B. Employers Liability Insurance: Part Two of the policy applies to work in each state listed in item 3.A.
 The limits of our liability under Part Two are: Bodily Injury by Accident \$ _____ each accident
 Bodily Injury by Disease \$ _____ policy limit
 Bodily Injury by Disease \$ _____ each employee

- C. Other States Insurance: Part Three of the policy applies to the states, if any, listed here:

- D. This policy includes these endorsements and schedules:

- 4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All information required below is subject to verification and change by audit.

Classifications	Code No.	Premium Basis Total Estimated Annual Remuneration	Rate Per \$100 of Remuneration	Estimated Annual Premium
-----------------	----------	---	--------------------------------------	-----------------------------

Total Estimated Standard Premium \$

Expense Constant \$

Minimum Premium \$

Countersigned by: _____